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A REËXAMINATION OF PSYCHIATRY IN ITS RELATION TO MENTAL HYGIENE

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IN A period of crisis, there is occasion to reëxamine and to reëvaluate some of those things that we have taken for granted. As psychiatrists we need to realize that we are at a crossroads and that we must choose which of two paths to follow. Necessarily we are concerned with the mentally ill. We must decide to what extent we are concerned with those not—as yet—in such a condition. Are we concerned with mental health—or only with mental illness? Are we interested exclusively in the contribution of psychiatry to mental illness; or are we interested also in the contribution psychiatry can make through mental hygiene, as a vital force permeating the education, training, and adjustment of "normal" children and "normal" adults? This decision is of momentous importance and it must be made, for the course of action that the logic of relationships dictates should we choose the second course is at many points at variance with, and sometimes contradictory to, the course we have largely been following, which is influenced primarily by the first view.

The historical development of psychiatry took place backward, as far as any logical approach to the problem is concerned. The logical course for the scientific investigation of disorders of human behavior would have been like that of anatomy. Here the focus was originally upon normal anatomy, and when the anatomy of the normal had been adequately described, the focus was shifted to pathological

anatomy. This approach made it possible to recognize with reasonable clarity what should be considered abnormal, by reason of its deviation from what had come to be recognized as the normal. For historical reasons, to be discussed presently, the approach in psychiatry has been chronologically the reverse.

Psychiatry developed in the insane asylum from the medical study of those individuals whose behavior was so abnormal that it was necessary to segregate them for their own protection as well as for the protection of the community. Having acquired knowledge and developed skills in the treatment of the mentally ill, the psychiatrist has advanced further and further from the confines of the mental hospital and now contributes significantly toward the understanding and modification of the behavior of individuals who are not considered irresponsible or insane. But we must remember that historically the approach in psychiatry has been from the study of the abnormal to the study of the normal. This fact has determined the orientation of psychiatry. At the present time the American Board of Neurology and Psychiatry regards experience in taking care of psychotic patients in a state hospital as general psychiatry, while experience with the problems of more or less normal children in a community clinic is regarded as special psychiatry.

It is natural, under these circumstances, that many psychiatrists should explain the normal in terms of the abnormal. As an example, one might cite the statement that any human action can be classified as a step in the direction either of murder, of suicide, or of incest. It is perhaps not surprising that some psychiatrists should even tend to think of all individuals as neurotic, or of normality as a special kind of abnormality. The terms "neurotic" and "abnormal" lose their meaning under such usage.

The reason for this inverted approach is historical. Within historical times, the medical profession has arisen as a specialized outgrowth of the priesthood, as its official symbol—the staff of Æsculapius—indicates. In at least some primitive societies, the responsibility both for the physical and for the moral well-being of the people is entrusted to a single profession—the profession of witch doctor or medicine man. Very early in the history of our profession, however, the

Asclepiads, priests of Æsculapius or Asclepius, the god of healing, became specialists in the healing art and ceased to function as priests. The respective areas of responsibility of the medical and of the priestly profession were defined, and the overlapping presented little problem. It is true that Hippocrates' great essay on the sacred disease illustrates a jurisdictional dispute, in his recognition that the problem of the convulsive state is no more sacred than that of any other illness, but such disputes created no serious schisms.

In the succeeding centuries of the Christian Era, this division of professional responsibility was maintained with relative ease because of the body-soul dichotomy of Christian theology.[1] It was in keeping with this division between the professions that mental illness was regarded as the province of the priest, not of the physician, and was treated by exorcising devils rather than by the healing art. But neither exorcism, punishment, nor preaching served to cure the psychotic of his delusions, and it was probably the failure of the methods of the priesthood to make effective headway that gave the physician the opportunity to establish himself in this area, in which his approach has proven much more valuable than that of the priest.

The conquest of the insane asylum by the medical profession, and its consequent reorganization into a mental hospital, resulted in the development of an area of human behavior subject to medical, not priestly, guidance. This, in turn, provided an opportunity for the introduction of scientific method into the effort to modify human behavior in an area not controlled by rigidly crystallized moral conceptions. Religious taboo forbids experimentation in the moral field, but once the behavior of the psychotic was recognized as not wickedness, but illness, the door was open for scientific study and experimental treatment. Despite the unfavorable character of the cases placed under medical control, the value of the scientific and medical approach was soon demonstrated.

Having established this area as his professional province, the physician, now a psychiatrist, began gradually to realize

[1] Differences did, of course, arise where moral and medical considerations impinged one upon the other. One might cite the opposition from a portion of the clergy to the use of anæsthesia or analgesia in childbirth, or to medical measures for the prevention of venereal disease.

that those things which were of value in the treatment of psychotic and grossly deviant individuals had also some usefulness in dealing with the less deviant and the more normal. The first large area invaded by the psychiatrist was that of the neuroses. The neurotic usually believed that he had an organic illness and sought the aid of the physician. Since the psychiatrist was a physician, no essential conflict over the delimitation of professional lines developed here. Such competition as occurred was between the general practitioner or the non-psychiatric specialist and the psychiatrist, with the gradual ascendancy of the latter.

But the neurotic was not the only type of case with which the psychiatrist found his skills to be of value. Increasingly, disturbed relatives sought his help in dealing with the problem child, the delinquent son, the promiscuous daughter, the husband who came home drunk on Saturday night and beat his wife. And the psychiatrist discovered that he had a contribution to make toward an understanding of the problems of such people.

Society, however, was not ready to assign to the psychiatrist responsibility for the management of such problems. Society regarded them not as medical problems, but rather as problems for the educator, the judge, or the clergyman. The psychiatrist, however, now conscious of his power, embarked upon an era of professional imperialism which has led to a confusion of interprofessional jurisdictional disputes.

These disputes represent essentially the competition of two systems for the control of human behavior. One of these systems is ancient and moral and draws its sanction largely from religion. The other is modern and medical and draws its sanction largely from science. Nowhere is this competition better exemplified than in the criminal court. Here a member of the legal profession, the district attorney, seeks to bring about the application to the defendant of the legal sanctions of the state and the moral sanctions of our concept of justice. The psychiatrist, on the witness stand, may lend his testimony to the inapplicability of the moral judgment and the punitive sanctions of the law, and the need for recourse to the medical system of treatment.

The psychiatrist has achieved his successes in part by reason of the fact that he abandoned the rigidities of the moral

approach and, instead, began to look for and to seek to correct the causes of deviant behavior. He approached his patient prepared to try to understand and to help, rather than to judge, to condemn, or to punish. Being constantly faced with the failures of the moral system, being repeatedly successful where exponents of this system had failed, the psychiatrist has become understandably skeptical of the value of moral and legal sanctions. The common man hears him most frequently represented in the rôle of a hired witness, paid to cheat justice by testifying that the defendant is not guilty by reason of insanity. As such, he presents a threat to the moral and legal systems of control—a fact that has done more to injure his status in the public eye than any other.

For our legal system clings to the nonsensical dichotomy that the convicted is either fully responsible—in which case the punishment prescribed by law is to be carried out—or insane, incapable of judgment and thereby incapable of guilt, and, therefore, not to be punished, but, rather, subjected to medical treatment. This thinking reaches its acme in the provision that if a man or a woman condemned to death becomes insane, the sentence cannot be carried out, unless the condemned should recover sanity, in which case the execution must occur.

The psychiatrist, aware from his experience of the impossibility of drawing any such sharp line of responsibility as the law demands, must endeavor to make sense of this non-sense. But in doing so he must learn—as forward-looking penologists have learned to their cost—that the punishment is required not for the benefit or the reformation of the offender, but for the mental comfort of masses of more or less law-abiding citizens. The medical system of control is chiefly individual-oriented. The legal systems of control are chiefly society-oriented.

The law-abiding citizen certainly has temptations and desires to take that which is not his, and at times to resort to violence. That he does not do so is related to the fact that, when such temptations arise, he keeps continually in the forefront of his mind the fact that such actions are wrong and deserve punishment. By this device he keeps himself both law-abiding and comfortable. But when another does in fact flout the law, tensions arise in the law-abiding citizen. Justice

must be served. The eternal truths for which he has given up his baser impulses must be vindicated. His tensions mount. The equilibrium of his personality may be threatened until "justice is done," or until he is convinced that "justice will be done." It is for this reason that, despite the fact that the psychiatric imperialists have from time to time made sharp and often justified attacks upon penal officials—whose success in dealing with the problems assigned to them is, it must be admitted, not all that might be desired—and despite the fact that occasionally a warden may be unseated and a new one substituted in the political struggles of our life, penal officials as a profession have sat secure within the massive walls of their institutions, relatively untroubled by the psychiatrists' attacks. They are always confident that if the matter comes to an issue, they can count upon the overwhelming support of law-abiding citizens for the contention that criminals must be held responsible for their acts, that justice must be done, and that the deliberate offender must be made to suffer for his misdeeds.

The irony of the situation lies in the fact that the distinction between these two systems for the control of human behavior —the moral (religious, ethical, legal) and the medical—in the last analysis is a spurious distinction in that both systems rely upon the same fundamental elements, and the difference is not one of kind, but merely one of emphasis. These systems are based upon two methods for the control of behavior, as follows:

1. To seek directly to motivate toward desirable behavior; to disapprove or punish that behavior which is considered bad and to approve or reward that behavior which is considered good. This may be called a moral approach.

2. To seek out the causes for that behavior which is considered deviant, undesirable, or bad and try to remove them, and to seek out the causes for that behavior which is considered conforming, desirable, or good and try to promote them. This may be called a scientific approach.

In practical functioning, both systems of control make use of both of these approaches, and the difference between them in practice is merely one of stress. The physician who urges the child to take the nasty medicine in order to get well, and praises him for doing so, is using the hope of reward and

moral sanctions no less than the clergyman who urges the child to resist evil temptation in order that he may have a saintlike character or that he may go to heaven. And the clergyman who demands the closure of a house of prostitution is seeking to remove a source of moral infection just as the surgeon who removes diseased tonsils is removing a source of bacterial infection. The most extreme exponent of the moral approach will recognize that he cannot expect a man to show the same respect for the property rights of others when his family are starving that he may be expected to show if they are suffering no want—that this is a situation in which a cause for criminal action must be removed before a moral prohibition can be reasonably expected to operate. And the most extreme practitioner of a strictly medical and "non-moral" approach will, if he is honest with himself, have to recognize that he frequently depends upon moral suasion, upon praise or censure, upon stimulating the hope of reward through recovery or the fear of further illness or death, to bring his patient to accept the hypodermic needle or the surgical operation. The non-psychiatric physician often understands this better than the psychiatrist, because he has not moved so far from the thinking of the common man.

In other words, the psychiatrist who maintains that his approach is totally scientific, and that he is not concerned as a psychiatrist with moral values, is self-deluded—or he is no psychiatrist. Science, to be sure, is not concerned with values, but only with formal relationships between observable events. Science can be used to injure or to kill as well as to heal. But the psychiatrist is by definition a practitioner of the healing art. As such, he has accepted a moral obligation —the obligation to seek to heal his patient. Science never gave him such a value. It merely gives him tools for accomplishing his purpose. And he found that when he approached his patients with a desire to understand (a moral value) and a desire to help (a moral value), it was advantageous to his work as a physician to suspend moral judgment in order to permit his patient to bring his real problem forth.

This suspension of moral judgment was, therefore, not fundamental, but only tactical. The psychiatrist, indeed, cannot disavow moral values without disavowing his rôle as a physician—his obligation to use the confidences the patient

gives him only for the good of the patient and for the advancement of the healing art. This is a tradition built up through centuries, and the psychiatrist who maintains that he is not concerned with moral values would be unhesitating and merciless in condemning a fellow who sought to make capital from the violation of this professional taboo. Further, he would unhesitatingly speak for, and as a member of, the psychiatric profession in condemning such a practice.

I have dwelt on this at some length because it is fundamental. As purely scientific workers, we may not be moralists. But the moment we accept ourselves as psychiatrists, the moment we avow the purpose of helping the patient to get well or to become adjusted, in that moment we become moralists. Understanding this fact is fundamental to understanding that the scientific and moral approaches are not antagonistic, but complementary. As a general rule, we suspend moral judgments in our work simply because we can better achieve our objective by so doing. But we cannot dispense with moral pressures, although we usually depend upon others to exert them in order that we may remain in a position of apparent impartiality.

We must, of course, recognize two common deficiencies of the moral approach as it is applied. By its nature it tends to create a literalness in the minds of those whom it influences most strongly, and this literalness means following the letter, often at the cost of the spirit. For the same reason the moral approach is slow to adjust itself to changing conditions that alter the moral significance of various acts. Its cultural lag is likely to be pronounced. The frequently destructive effect of these sources of weakness is important in that it has given in many circles a certain distasteful connotation to the very word "moral."

In effect, the decision that, as psychiatrists, we must make is as follows: to limit ourselves to relatively exclusive jurisdiction in a small area of human maladjustment, or to embark upon an enrichment and a synthesis of improved and more intelligent methods of social control for the minor degrees of social and personal maladjustment and ultimately for our whole social order. We must either keep psychiatry as a special field concerned only with definite and medical *abnormality,* or broaden it into a real mental hygiene which will be

of value to the man who cannot fairly be considered abnormal.

This problem cannot be solved by considering abnormality as a usual or universal state, by claiming that all men are abnormal and therefore subject to the psychiatrist. Under such usage, we should have to consider abnormality a normal state. The public will not swallow this distortion under which both "normal" and "abnormal" become meaningless. The development of a real mental hygiene will require coöperation *with,* not simply the handing down of an opinion *to,* non-medically trained persons, and will be impossible of real fulfillment as long as we psychiatrists cling as rigidly as at present to a craft-union philosophy.

This philosophy will effectively serve to keep us masters of our special bailiwick. The experience of the common man gives him no basis for judging the wisdom of different methods of treating schizophrenia, and he must rely upon the word of the expert entirely. The experience of the intelligent layman, however, gives him some capacity to understand the problems and maladjustments of the essentially normal man or woman. While our society is no longer threatened by suspending the moral approach in dealing with those who can be considered mentally ill, it cannot afford to give up the moral approach through which the conforming citizen protects himself against temptation. Society will not give the control of the normal into the hands of the psychiatrist because it does not trust him to "see justice done" and morality preserved—and without some form of morality, no society can exist.

To make the contribution of which we are capable toward aiding the normal man, we must be willing to resign any Olympian prerogatives. We must learn to collaborate. We must learn to speak language that others can understand. We must make our wisdom understandable to people not trained in psychiatry. The barbed-wire entanglement of technical jargon that prevents effective questioning of our opinions as authorities on mental illness only serves to isolate us from those who should hear us when we bring our contribution to aid the more-or-less-normal man.

For this reason we can never make our real contribution to mental hygiene until we are willing to pare technical language to an absolute minimum and to go to the trouble of expressing our insights in clear and common language. Spe-

cial terminology is necessary to some extent in special fields, but it is to be regarded as at best a necessary evil. We cannot have a real mental hygiene until we have a democratization of some measure of psychiatric understanding.

There will be those who will maintain that it is impossible to express their knowledge in common language and that their technical language is necessary. We are entitled to wonder if at times the real motivation here is not a sense of need to keep the knowledge, and particularly the appearance of wisdom, for the chosen, and a realization that if it were not expressed in technical language, it would be too easily understood—that it is essentially too simple rather than too difficult to put into common language.

Let us remember that for centuries intelligent laymen have had experience with human personalities, and that the language of common use that has been developed to describe it is both flexible and comprehensive. The drama and the novel have been well-developed arts for some centuries, and have been found effective in presenting the emotional conflicts of normal—and even of disordered—personalities. The shrewd and intelligent layman has a significant fund of understanding of human nature. *A real mental hygiene must be based upon an extension of this understanding, because it will have no real influence except as it is understood by the shrewd and intelligent layman. An approach that explains the slightly deviant in terms of the seriously deviant can never create a mental hygiene, because it explains that which the layman knows but slightly in terms of that which he understands not at all.* As a matter of fact, it frequently leaves the physician who is not a psychiatrist as perplexed, frustrated, or perhaps as disgusted as the layman.

The fact must be accepted that many of the members of other professions and other disciplines are not readily won to collaboration with a psychiatric point of view. This, however, no more justifies us in failing to make the effort than we would be justified in failing to make a therapeutic effort with a patient committed to our care because we found him in a resistive frame of mind. Psychiatry, through mental hygiene, has a contribution of major importance to make to the organization of our life and our society. There is an obligation

upon us as psychiatrists to seek to make this contribution. We cannot do it unless we orient our thinking accordingly.

To sum up, if we, as psychiatrists, are concerned with mental health, rather than merely with mental illness, we must adapt ourselves accordingly. We must learn to understand and to respect the psychodynamics of the community as well as the psychodynamics of the individual. We shall never be able to accomplish the task of mental hygiene as long as we are content to be identified by the common man chiefly as hired witnesses paid to cheat justice by proving the defendant not guilty by reason of insanity. To alter this, we must to an increasing degree make our orientation social as well as individual. We must develop understanding of, and respect for, the dynamics of social structure and social change. We must learn to collaborate. We must build an understanding of mental health upon the foundation of the human insights of shrewd, intelligent laymen, rather than upon a technical vocabulary developed for describing the grossly abnormal and the mentally ill.

EATING IN GROUPS IN WAR TIME

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THE war has increased the number of children whose care is partly or wholly entrusted to persons outside their own family circles. The potential dangers of institutional care are fully realized, and parents will keep children in their own homes whenever this is feasible. The danger of emotional deprivations in semi-institutional care—for instance, in day nurseries—though less acute, is present and deserves study.

Day nurseries differ widely. Some of the suggestions made here will be taken for granted in certain day nurseries, while they will be unknown in others. The fact that a house is clean, well organized, and running on schedule does not suffice to make it a place in which it is desirable for children to spend the greater part of their waking hours. The care of children must be in the hands of persons interested and fond of them as individuals and well acquainted with the tenets of mental hygiene. Then the above mentioned danger of emotional deprivations can be almost completely avoided; otherwise institutionalism may flourish.

A great deal has been written about feeding problems and their emotional implications, but the whole literature is geared to the needs of the mother in the home. In group care the problems are somewhat different. A mother whose child is an eating problem and who spends much energy in coaxing and imploring her child to eat, is told: "Serve the meal; don't fuss or cajole; don't show any concern. Take the food away after twenty or thirty minutes without comments of any kind." This is good advice to the majority of mothers, as it will reduce their oversolicitousness to a normal level. But the same advice given to workers in day nurseries—or in institutions—may yield quite different results.

I have seen workers who showed complete indifference as to whether a child finished his food or not. "Take it or leave it," was the attitude, expressed in words and gestures that

verged on sarcasm. Such an attitude makes the feeding of fifty or sixty children a much easier job, but it is detrimental to the children.

To state it quite definitely, a child needs the reassurance that the adult who takes care of him is genuinely interested in him—interested in what he does and in how he looks—is pleased when he enjoys his food and sorry when he refuses it. Both hypertension and cold indifference represent an undesirable climate. A child should not be urged or bribed to eat, but he should be encouraged and helped.

The most obvious feeding problems—*e.g.*, those apparently healthy children who persistently refuse food—are almost nonexistent where groups of children eat together. Moreover, children who were eating problems at home often develop a hearty appetite. *The* problem of eating in groups is the widespread *lack of enjoyment* of food and mealtime.

Let us turn to younger age groups in order to win a better understanding of the needs of the two- and three-year-olds. To-day we know that an infant should always be nursed or fed on the lap, in the hospital as well as in the home. Food should be given in an understanding and affectionate way. For the two- or three-year-old, the equation of food and love still holds true; therefore mass feeding must be avoided.

This, then, is the eating problem in group care: food taken in a milieu of fear and enforced silence will be less wholesome, in the physical sense of the word, and children whose meals are daily for long periods served in an atmosphere of strain and regimentation are suffering severe emotional deprivations and may be expected to show the effects of it in later life.

To make mealtime pleasant, to remove all unnecessary restrictions, to put children and adults at ease, should be a major concern of those to whom the organization of day nurseries is entrusted. None of the following suggestions involves extra expenditures.

Table Arrangements.—Long tables seating a great number of children on wooden benches have disappeared from almost all our orphanages, but such tables are still to be found in day nurseries. They could be replaced by tables for from four to eight children. Eating in a day nursery should resemble mealtime in a family, not in an overcrowded canteen. Children should not be required to be mute during their meals, nor

should there be a deafening noise, making it almost impossible to hear what the other person says. Under the latter condition, children will learn quickly that they have to shout if they want to make themselves understood. Therefore, not more than about forty children of pre-school age should eat at the same time, and if the room is not large, the number should be even smaller. In a large day nursery, the problem may be solved by having two shifts in the dining room or, better still, by letting the younger children eat in their playrooms. The latter arrangement involves slightly more work for the adults in charge, but it may save in nervous strain more than it costs in physical labor.

Waiting.—Contrary to the views of some administrators, children do not win strength of character by "learning to wait." A considerable amount of waiting for one another is unavoidable in group care, but it should be reduced to a minimum and, as far as possible, children should not be requested to be idle while waiting. Often the procedure is this: After the children have waited for one another to get washed and combed, they have to wait at the door of the dining hall. After entering, they have to wait until everybody is seated and quiet—sometimes until everybody is served —and grace has been said. Between hand-washing and the first spoonful of soup, often a full hour passes and sometimes longer. The teacher may find this one of the most strenuous hours of the day, as the children are irritable and quarrelsome because of the feeling of boredom and frustration.

In many nursery schools, children lie down for a short rest before mealtime. The quiet period prepares them better for the meal than the excitement of play. For the same reason tension generated by enforced silence and waiting should not precede mealtime.

Table Manners.—The child's gradual adaptation to our standards, difficult as it is, is necessary. While some things have to be taught, many changes in children's behavior are brought about by spontaneous imitation and maturation. Every child is anxious to proceed on the road toward grownupness and thus will give up childish ways if we give him time and the general feeling of being accepted and loved. In the interest of the child's mental health, we should limit our intervention to those areas in which it is indispensable. With

young children, only a few and elementary rules of table manners should be required. Achievements should be emphasized, slips overlooked when possible. All children like food that can be eaten with the help of the fingers; this is true even for children who wield spoon and fork skillfully. Sandwiches are liked for this reason and so are carrot sticks and raw fruits. Picnics in some nearby park should be planned fairly often when the weather permits them. A meal taken in an atmosphere of joy and relaxation is a building stone toward the child's future mental sturdiness.

Quantity of Food.—Small first helpings should be given, but as many seconds and thirds as the children ask for. I remember visiting a day nursery where the children were not allowed to ask for third helpings although there was food left. The reason given was that it would teach them "piggish habits." (This is an example of how a person who experienced hurtful deprivations in her own childhood may inflict similar deprivations on the children entrusted to her, rationalizing them as "educational.")

It is better to give a small glass of milk and to have a small pitcher for refilling the glasses.

If a child's appetite gets suddenly quite low, or if he skips a meal or vomits, a note should be made of it and the child watched unobtrusively. This is done in most day nurseries and need not be mentioned here. Sometimes, however, the teacher thinks that the child's refusal to eat has no physical reason. He has had a conflict in the morning with another child and demonstrates his protest by not eating. A day later we may learn that the child is ill. His non-eating was not a consequence of his quarrel, but both—his quarrelsome mood and his lack of appetite—were the first signs of the approaching illness. Therefore every irregularity of a child's appetite should be noted.

Self-help of Children.—Young children will eat their food with more gusto if they can help in preparing and serving it. Children of five and even four years of age can pour milk, tomato juice, or water, serve food, pass plates with bread. During their morning playtime, they can help in the preparation of the food—washing potatoes or carrots, peeling boiled potatoes, shelling peas, slicing bananas for fruit salad, spreading butter on bread, making cookies. Food and kitchen

utensils should be brought into the children's playroom, where a special clean table is reserved for this work, and a number of white aprons awaits the prospective "helpers."

Preparing food can be used for another purpose also. We want the child to learn that our hands must be clean before touching food. A child who is sent back from dinner to wash his hands will comply reluctantly, whereas he will act speedily and cheerfully when told that he cannot squeeze oranges unless his hands gets a good scrubbing. We have found that this requirement of clean hands carries over to mealtime. In the family home the child can actually help in the kitchen and thus see the whole process, but this will hardly be possible in the day nursery. Nevertheless, any help in the preparation of food gives a stronge sense of achievement.

There are two main sources of emotional security—being loved and accepted and being "able to do." Even in the best day nursery, children are necessarily deprived of a good deal of motherly affection. Thus it is the more important to make use of everything that can enhance their feeling of achievement. The five-year-old will feel rightfully proud when "his" potatoes or carrots are served at mealtime.

Food Dislikes.—The biggest obstacle to making mealtimes pleasant is the view that children should not have any dislikes or preferences in the matter of food. Before C. Davis carried out her experiments with the self-selected diet of infants and children, it was assumed that children are unable to select a balanced diet or to keep from overeating when allowed to choose from a variety of dishes.

Since 1931, her principles have been applied to the group care of children.[1] In several wards of the Children's Memorial Hospital in Chicago, the young patients and convalescents were permitted to select their food from a cart wheeled in at mealtime. There were no limitations as to quantity or combination, and dessert was served even when the first course had not been finished. The weighing of the waste of edible food showed that, under this arrangement, there was considerably less waste than when the children received filled plates and were not given their dessert unless the plates were

[1] See "A Practical Application of Some Lessons of the Self-Selection of Diet Study to the Feeding of Children in Hospitals," by Clara M. Davis. *American Journal of Diseases of Children*, Vol. 46, pp. 743–50, October, 1933.

cleared. As there was no dawdling or messing around with disliked food, mealtime was shortened and labor saved. These two practical reasons—saving of food and labor—certainly count in war time.

From the first day this method pleased both children and nursing staff. It is so simple and can do so much to remove nervous strain, friction, and punishment from meals that it should at least be tried by day nurseries.

Often there is the assumption that small children have to be cured of their food dislikes and that it is "educational" to make them finish the first course or else make them go without dessert, even though the nutritional value of the sweet dish or the fruit served for dessert may be higher than that of the first dish.

This is a purely moralistic point of view not substantiated by experience. In older children food likes and dislikes have ceased to be emotionally charged, and most of them will disappear before puberty, provided they have not been the subject of bitter struggles between child and adult. In older children, vomiting becomes limited to cases of physical illness; whereas the younger child may use it as an effective method of registering protest. The children who do this should not be considered abnormal. It has been found that a child will resort to this form of protest only when his other means of self-defense have been cut off.

Disgust.—Besides the aforementioned dislikes, many small children show at some stage of their development intense disgust for some kind of food. Usually the disgust is shown before the child has even tasted the food. The more a child has experienced severe oral or anal deprivations in infancy, the more outspoken will the disgust be. When harsh methods have been used to stop him from thumb-sucking, when weaning or toilet training was early and abrupt, or when the child suffered from severe stomach upsets, then disgust attached to some kind of food, as well as increased messiness, may be expected.

We do not know why a child chooses a certain food for his aversion, but we know that some foods are chosen more often than others. Spinach, cooked carrots, tomatoes, and scrambled eggs are disliked because of their color and consistency, while fish, cabbage, and cauliflower may be rejected

on account of their odor. Dark raisins served in hot cereal may be refused, although raisins put in by the children themselves are well liked.

Children who have been helped by a psychiatrist to verbalize the reasons for their disgust have expressed connotations that would be repulsive to any adult.

Children's feelings of disgust are not infrequently as irrational, as highly charged emotionally, and as interwoven with phantasies as are childish fears. While the latter have been extensively studied, the problem of nausea has received but little attention; hence it may be worth while to say a few words about its genesis.

After leaving the paradise of infancy, children in all cultures are required to observe an increasing number of taboos, and again in all cultures, not only in our own, educators have called upon disgust to insure the avoidance. By precept, example, and punishment the child is taught to display disgust and quickly comes genuinely to feel it. A comparative study of various ethnological groups shows that there are certain substances that are considered offensive in all cultures, while other substances are tabooed only by some groups, and emphasis changes from group to group. The main excreta of the human body are taboo in all cultures, while blood, saliva, and perspiration may or may not be included.

Foods highly appreciated by one group are loathsome to another. A proverbial example is the rotten eggs considered a delicacy by the Chinese. The feeling of repulsion is brought about by visual impression and odor. As the goal of disgust is avoidance of contact, we can now understand why taste cannot be its criterion. The repulsion must be felt before the substance or food is touched, let alone put into the mouth.

Comparing our cultural restrictions with others, we find that apparently the list of offensive items is not more extensive with us, but that we attempt to instill disgust at an earlier age. One of the consequences of this is that the child, confused, but trying to conform to our demands, expresses repulsion toward more things than we meant him to. In this fact is to be sought the root of many of the food aversions of early childhood.

The child who calls every dog "Scottie" or "Stumpy"

(after the first dog he knew) and every man "Uncle," is considered cute, but the child who shows disgust toward a dish that looks or smells to him like excreta is considered naughty. In both cases his conclusion is wrong, and based upon insufficient experience; nevertheless, the underlying mental process is right.

Iron Rules.—At an age when children have not as yet a correct evaluation of time, they do remember sequences. If the same sequence in getting ready for mealtime is observed daily, they will soon know the next step that is expected of them. While rules are therefore desirable, the customary arrangements should sometimes be subject to exceptions. Picnics have already been mentioned. They can be held not only in the park or the zoo, but also on the roof of the building or in the back yard. Whenever there is a good reason to have a "party," this opportunity should be used to bring joy and merriness to the mealtime. In a large group of children, it may be impossible to celebrate each child's birthday, but the birthdays that occurred during a month can be celebrated on one day. A small supply of candles and colored paper, a victrola, and songs will lend glamour to many parties. The long table and long rows of benches that look so "institutional" when used daily appear very festive when introduced only for special occasions. Of course every holiday marked on the calendar should be celebrated by a festive meal.

Food Shared by Adults and Children.—This subject is more important with older than with young children. Younger children need a partly different diet and even older youngsters should still not share all the food habits of adults, but beyond these age-specific needs, children and the adults in whose care they are entrusted should partake of the same food. The reasons have been well expressed by Aichhorn:

> "[The child] can never believe that his counselor is in sympathy with him and on his side, if he gets cornmeal mush while the counselor gets roast beef. In our institution there was only one menu, cooked on the same stove and in the same utensils. This must be a basic principle. The displeasure over the difference in what counselor and pupil get to eat creates a great distrust, which is carried over into the whole relationship."[1]

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[1] See *Wayward Youth*, by A. Aichhorn. New York: The Viking Press, 1935. p. 151.

There are other reasons why there should not be a double menu: it not only involves a considerably greater expenditure in money and labor, and greater waste of food, but the food prepared for children only has a tendency to fall below standards. As Rudolph Reeder puts it: "The child [becomes] the victim of indifferent and easy-going cooks and their helpers, who think almost any sort of attention and preparation will do for a 'lot of children'." [1]

The best safeguard against this is to permit only those differences between the children's and the adults' diet that would be allowed for in a family.

Studies.—Our knowledge of children's attitudes toward food is still limited, and very little is known about the relationship of their general well-being and oscillations in their stability, and their changes of appetite. Such factors cannot be studied in families, but well-equipped day nurseries could render a double service to the nation by enabling students or volunteers in training to study these correlations in their child population.

Teachers' Aids.—Day nurseries were originally places where children could be "parked." To the purely custodial care an educational program was later added, and to-day this program compares favorably with the program of an average nursery school. However, as the children spend many more hours in the day nursery, their care may be partly entrusted to nursemaids who not infrequently have no training in child development. At the present time, when excellent short training courses are available for volunteers, it should be possible to "liquidate" nursemaids who are ignorant of the basic principles of mental hygiene. In hospitals we have to-day fully trained nurses and partly trained nurses' aids. A similar arrangement is needed in day nurseries.

While the hours of play are under the supervision of fully trained teachers, mealtime is often entrusted to the nursemaids. Their instructions are to keep up certain standards of quiet, order, cleanliness, and speed. On account of their lack of training, they may find it difficult to maintain the standards set, and if they resort to methods that must be called brutal, the director or the teachers may never come

[1] See *How 200 Children Live and Learn*, by Rudolph Reeder. New York: Noble and Noble, 1920. p. 11.

to know it. If working under great strain, even a basically kind person may resort to such means.

In former times brutality toward little children was fought by people who, being humanitarians, resented cruelty—including cruelty toward animals. To-day we know that children treated in harsh ways may develop into the distorted adults of to-morrow, who inflict suffering upon others or indulge in crime. The roots of their perverted behavior are to be found in their own mistreatment in childhood. All of us who take the tenets of mental hygiene and the predictions based upon them seriously must help toward the realization of those principles in the group care dictated by war emergency.

MENTAL-HYGIENE PROBLEMS OF STUDENT NURSES *

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DURING the past decade, nearly all branches of education have undertaken a critical evaluation of their basic aims and tenets. Such periodic examinations are necessary if education is to remain sufficiently flexible to meet the challenge of changing times and needs. As an educational endeavor, nursing training is of comparatively recent origin. Like many other branches of education, it had humble beginnings and a desperate struggle to achieve acceptance and recognition, but it has since undergone a rapid flowering and development. Its program has expanded so rapidly, and so many new techniques have been added, that there has been little time or opportunity to reëxamine its fundamental aims and functions. Yet an evaluation of basic principles and a critical appraisal of the present aims of schools of nursing are necessary if this discipline is to fulfill its expressed obligations.

What is the function of a training school? The old answer, "To train good nurses," is not adequate because it merely stimulates another question, "What is a 'good nurse'?" A good nurse is an intelligent, healthy, and wholesome person of estimable character who is trained in a set of medical techniques in order to be of maximum service to the sick. Modern nursing and medical opinion, however, constantly emphasize that only a small part of this "maximum service" will depend upon purely medical knowledge and technique. In order to achieve personal and professional success, the "good nurse" must have a wholesome, healthy personality, a character that impels respect, personal integrity, and an ability to adapt herself to new situations and problems. A

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splendid intellectual endowment and excellent professional training are worthless if the nurse is dishonest, unreliable, or otherwise lacking in integrity. Equally, she will not be a success, either personally or professionally, if she is emotionally unstable, lacking in adaptability and self-reliance, or so disorganized in her personality structure that she is unable to work or to associate with others. Modern nursing education must strive to develop more than a woman trained in medical techniques. If the most important attributes of a nurse are character and a well-organized personality, then the training program must endeavor to produce a mature, poised, balanced woman who possesses personality traits that will be an asset in her work and in her life. Educational programs designed only for intellectual development, and the assimilation of enough medical knowledge to pass state-board examinations and to secure a position, will not necessarily produce a mature, balanced woman who will be a credit to her profession. Knowledge will be of little value if the underlying personality structure is unstable and unwholesome.

These concepts are not new; they have long been accepted by nursing educators, who have attempted to put them into effect in two ways—namely, by actual teaching and by the example of the faculty. Lectures have been given on "Ethics" in which the spiritual values of the nursing profession have been described, and the student nurse has been urged to accept these standards as her personal ideals. The directress and the faculty have attempted to provide wholesome examples in their professional and personal lives, with the hope that the student would emulate this behavior. In many instances this approach has been successful; in others, it has been a complete failure because it has failed to recognize one fundamental principle. It has assumed that the student comes to training school as a personality "blank," upon which the impress of Florence Nightingale can be stamped, and that the girl can think, feel, and behave in a prescribed manner if she will only "will" it sufficiently. Students do not come as amorphous and unshaped personalities, however, but rather as complex personal organizations of what they have thought, felt, loved, hated, and experienced during the course of their lives. An attempt to instill values

from a purely intellectual standpoint will be futile if the student is emotionally set and fixed to believe otherwise. It is not so easy to overcome one's beliefs and one's lifelong behavior patterns.

Modern collegiate education is now placing emphasis on the development of the whole person. Educators once assumed that their obligations were fulfilled by creating an environment favorable for intellectual growth and exposing the student to a learning situation. Later, they became aware of their responsibility for supervision of the physical health of the student, and this led to the creation of a student health service. This closer medical supervision soon revealed that large numbers of young men and women were struggling with serious emotional problems, and that personality-guidance facilities were necessary if the total hygienic needs of the student were to be met. The provision of such facilities for promoting the mental and emotional health of the student is now considered a proper part of the general health program of many colleges.

Schools of nursing are following this same educational philosophy, but there has been a distinct time lag in putting it into effect. Systematic health services are now being instituted [1] and haphazard methods are being discarded except in the field of mental hygiene.[2] In 1938, there were no facilities for mental hygiene in ten leading schools of nursing,[3] and since then there has been only an occasional mention in the nursing literature of a concrete guidance program.

The student nurse is a person. She brings her own inner life, her feelings, and her difficulties into the training-school situation. She retains her relationship with her family and her friends and reacts to the problems of these groups. Her own personal interrelationships and orientation present per-

[1] See "Health Service in a Nursing School," by Elsie Davies and Harriet Frost. *American Journal of Nursing*, Vol. 40, pp. 421–27, April, 1940.

[2] See "Mental Hygiene and the Student Nurse," by Amy N. Stannard (*American Journal of Nursing*, Vol. 35, pp. 851–55, September, 1935); "Student Personnel Work," by Marjorie Bartholf (*American Journal of Nursing*, Vol. 38, pp. 447–54, April, 1938); and "Guidance Programs in Schools of Nursing," by Hilda M. Torrop (*American Journal of Nursing*, Vol. 39, pp. 176–86, February, 1939).

[3] See Torrop, *op. cit.*

plexing problems that must be solved. The student does not shed these inner conflicts when she dons a uniform, but carries them into the classroom, the ward, and the study hall. Many of these difficulties and problems may have their genesis outside the hospital environment, but the personality response to these conflicts will be manifested in the hospital as undesirable character traits and behavior patterns. Further, these unwholesome patterns of reaction cannot, as a general rule, be corrected either by emulation of superiors or by lectures on ethics. The only reasonable method of attack is one that assists the girl to work through the problem. Sooner or later such a guidance program must be integrated into training schools and provide facilities for assisting the student in adjusting herself to the new environment and problems.

At least two questions arise in response to such a suggestion. First, is such a program necessary? After all, the majority of student nurses complete their training program with apparent success. Are the students really in need of guidance and help in addition to the regular training-school facilities? In 1939 a questionnaire study[1] revealed that many students were perplexed by numerous problems and distressed by personal conflicts, and usually these girls had no guidance except from their classmates, who were equally uninformed and inexperienced. Actual experience with a group of student nurses will convince any open-minded observer that a large percentage are in need of and willing to accept guidance and counsel. The training-school experience is usually the last step in the development and maturation of adolescent years. Usually it is the last opportunity of individuals to form good basic patterns of reaction for the remainder of their lives. In general, the reaction patterns adopted by the end of training school will be the permanent, basic modes of response. For these reasons the student nurse needs and deserves help and guidance during these crucial years.

The second question is equally pertinent: Is it a proper function of the training school to attempt to treat the emotional problems of its student nurses? Nursing educators

[1] See Torrop, *op. cit.*

have assumed the responsibility for the protection of their students from metatarsalgia, contagious diseases, and tuberculosis.[1] If the training school protects the physical health of its students, it would appear that there is an equal responsibility for the promotion of mental health. The alternatives to such a progressive policy are wasteful of human material. Long experience has shown that admonitions to the student to "get hold of yourself" and "act more sensibly" are merely wasted respiratory effort. The Spartan policy of instantaneous dismissal of any student who appears emotionally unstable may deprive a potentially wholesome girl of an opportunity to reorganize herself. The final alternative of doing nothing except hoping that the girl will "straighten out" usually results in the maladjusted student's floundering through training to become an equally maladjusted graduate, who is neither a credit to her school, a satisfaction to herself, nor much assistance to her patients. Schools of nursing have been proud of their intellectual standards and low incidence of physical disease. It is now their duty to become equally interested in the emotional health of their students.

II

The personality problems of student nurses are often not apparent to the faculty. Serious emotional problems may develop and remain hidden behind a façade of aloofness or stolidity. Usually the students attempt to hide any emotional upset, fearing that an admission of nervousness may endanger their graduation or their recommendation for positions. The following case reports illustrate the development of serious personality disturbances that were apparently unrecognized.

Case 1.—A graduate nurse, aged twenty-eight, was referred for psychiatric examination because she appeared preoccupied and unable to concentrate on her ward duties, and occasionally made queer, irrelevant remarks. Examination disclosed considerable emotional blunting, uneven and erratic psychomotor activity, and some disconnection of thought processes. It was obvious that she had a chronic schizophrenia and that the process was about to undergo an acute exacerbation.

The patient had been reared in a home devoid of affection and consideration. Her parents were grasping, selfish individuals who resented

[1] See Davies and Frost, *op. cit.*

the daughter as an expense and an obligation. From early years she had felt unwanted and lonely, and had developed into a shy girl with marked feelings of inferiority and inadequacy. She had no friends because she never dared to invite them to her home. The home situation became so intolerable, because of the nagging and antagonism of the parents, that the girl entered nursing training as an escape. The father permitted this because it promised to pay a good return on his investment.

In training school the patient was a lonely, fearful girl who was almost incapacitated by her feelings of inadequacy. She led a lonely existence, had no friends, and seemed to live in her own thoughts. During the second year, she had an acute psychotic episode, which was ushered in by a period of panic and feelings of unreality. In the ensuing weeks she heard imaginary voices discussing her life, and had delusions of persecution. She realized that her condition was abnormal, but she had no one with whom she dared to discuss her difficulties. She was afraid that she would be sent to her hated home if any one learned of her condition and so she attempted to behave normally and to conceal her symptoms. Apparently none of the nursing faculty were aware of her mental illness in spite of the fact that she had an acute psychotic episode that lasted several weeks. She graduated from training school and was able to hold several positions, although she was always considered to be a queer, seclusive person. Her family demanded and received most of her earnings.

Shortly after the initial interview, the patient had an acute exacerbation of the chronic schizophrenic process. She became violently excited, hallucinated, and delusional and required hospitalization. The family were unwilling to be responsible for her care when they learned that she had changed from a financial asset into a liability. She was committed to a state hospital and died there after a residence of several months.

Case 2.—A young woman was brought to a psychiatric hospital by her parents because of overactivity, talkativeness, expansive ideas, and uninhibited behavior. This illness had begun a few months before while the girl was in training school. Psychiatric examination disclosed a typical manic-depressive psychosis, hypomanic phase, and the history indicated that this was the third attack of mental illness.

The patient was an only child who had always been allowed to have her own way and been granted every wish within the parents' means. At adolescence she had had a difficult period because of delayed and irregular menses; she had been emotionally upset about this. In the second year of high school, she had had an episode of depression that had lasted several months, and in the third year, a period of excitement had occurred. It had always been her ambition to become a nurse, but soon after entrance into training school she began to experience difficulties in adjustment. She resented her superiors, did not like the manner in which orders and directions were given, and considered the social regulations too stringent. Her response to this situation was the gradual development of a hypomanic reaction, with talkativeness, aggressiveness, and elated or irritable moods. She became quite grandiose in her manner and treated her teachers as inferiors, causing them to become resentful and exacting in their discipline.

The psychosis also brought about an increase in the patient's erotic drive, and she was rather uninhibited in conversation with physicians and patients. Occasionally she was late in returning to her quarters, and

on a few occasions she remained away overnight. This behavior soon gained her the reputation of being "wild." Efforts to discipline her were unsuccessful; she responded with impudence, antagonism, and new infractions of the rules. These disciplinary measures, moreover, led to the formation of delusions of persecution which were projected upon various members of the nursing faculty.

Her buoyant gayety, flighty conversation, and uninhibited behavior soon caused her dismissal from training school. The faculty recognized that she was emotionally unstable, nervous, and intractable, but apparently no one realized that she was undergoing the third attack of a major mental disorder. Her further course was that of increasing excitement, which finally necessitated state-hospital care.

Case 3.—A graduate nurse, aged thirty-two, was admitted to a psychiatric hospital because of morphine addiction, emotional depression, and a recent suicidal effort. She had been employed as a staff nurse and, although proficient in nursing techniques, was considered to be unusually quiet and shy and was obviously anxious, tense, and maladjusted. Shortly before the present episode she had been disappointed in a love affair. More recently she had had a severe dermatitis that had necessitated hospital care, and while under treatment she had become tense and depressed, finally asking for morphine as a sedative. When her addiction was discovered, she went to the roof of the hospital, intending to end her life by throwing herself down.

The patient was one of a large family reared under adverse circumstances. Her father was a psychopathic individual, and his brutality had a lasting effect on all the children. The cultural standards of the home were low, and the patient had no social or character training worthy of the name. The depravity of the father and the unhappiness of the home forced the girl into training school as an escape. In nursing school she felt inferior and unable to compete because of her lack of a social and cultural background, and suffered from loneliness and a sense of insecurity. These personality traits became her outstanding characteristics. She was always uncertain, fearful, and a little resentful because of her fancied inferiorities.

In the second year of training, one of her unmarried sisters visited her and confided that she was pregnant, and the patient secretly nursed her after a criminal abortion. A short time later another sister visited her, and a surreptitious visit to a physician revealed that she had recently acquired syphilis. The student was frantic about her sister and later became depressed, thinking, "It looks like none of us are any good. I suppose I'm going to be just as rotten as the rest of them."

These incidents increased her feelings of inferiority and worthlessness and she felt incapable of facing the realities of her life and making a new start. When menstrual cramps became severe, she began to take codeine, then progressed to morphine. Finding that the morphine and barbiturates diminished the pain of her personality conflicts, she became regularly addicted. She was careful to conceal this from every one and graduated from nursing school. By this time she had lost faith in all values and in addition to her morphine addiction, indulged in alcohol to excess and in other kinds of uninhibited behavior, excusing herself with the thought that it was hopeless to try to rise above her family standards.

It was apparent that all this was an attempt to avoid the pain of facing the realities of life.

The second year of training school was one of the really crucial periods in this girl's life. Her family problems reached a climax, and her own personal problems were becoming so severe that some solution had to be found. When asked by the physician why she had not consulted some one older and more experienced about all these difficulties, she replied bitterly, "Doctor, who do you talk to in training school about things like that?"

III

It is generally believed that a young woman enters training after prolonged deliberation with a full appreciation of all the factors that motivate her. It is assumed that she freely chooses nursing because it offers her the maximum opportunity for service and a career, possibility of advancement, and financial security. Usually, however, there are other, underlying reasons for making this vocational choice. In some instances, the applicant fully understands her real reasons for entering training; in others, she is only dimly aware of them or is totally unconscious of them. It is usually difficult to learn from an applicant the underlying reason for her choice because the real motivation is hidden by a rationalization which implies a commendable aspiration, "I have a desire to do something for humanity and to serve and help people." This may be true in a majority of cases, but in others it may conceal motivations that are the cause of severe emotional difficulties or the basis of future personality problems. In some instances, the real motives for entering nursing school are the basis of emotional problems that develop during training. The following examples disclose the real motivation in a number of students who, in gaining admission, offered the rationalization of a desire to serve:

1. An applicant was entering training against her own wishes because the father, an immigrant who held education and a profession in great esteem, had insisted since her birth that she become a nurse. She had considerable ability and interest in restaurant management, but felt obligated to conceal her own feelings and to gain admission to nursing school.

2. A girl wished to become a surgical nurse and gave many spurious reasons for her choice. The real reason was that since childhood she had had a morbid, thrilling curiosity about monsters and about scenes of blood and suffering, and she believed that this interest could be best satisfied by surgical nursing.

3. A student nurse had a deep unconscious hatred for her mother, who was an ardent Christian Scientist. The girl had an unconscious desire to antagonize and reject her mother by associating herself closely with the medical profession, which was in opposition to her mother's most cherished beliefs.

4. A student nurse had believed that she was socially rejected since childhood because of her parents' divorce. She hoped that becoming a nurse would give her sufficient prestige to overcome the family stigma.

5. A young woman entered nursing training because she hoped that working with patients would help her to forget her irritability and maladjustment, and her recent divorce which was due to her own instability.

6. A young woman entered training mainly to force her suitor at home to arrive at a definite conclusion regarding his matrimonial intentions.

7. An applicant found herself possessed of powerful emotional drives of such a character that they caused her embarrassment and shame. This led to such feelings of unworthiness that she hoped to expiate her guilt by serving others in a humble capacity.

IV

Into the freshman year of nursing training come students of every personality pattern—the sophisticated and the naïve, the arrogant and the timid, the sheltered and pampered and those who have felt rejected at home. It is the function of the nursing faculty to formulate a program and a system of regulations that will mold these diverse personality types into responsible, wholesome, and healthy graduate nurses. On arriving at training school, the student finds that she must adapt herself to a new kind of life and behavior, and this initial adjustment is often provocative of emotional tension.

Whenever the student finds that she and her new life are not harmoniously adjusted, she experiences an emotional reaction in keeping with her personality pattern, usually either resentment or anxiety and depression. The girl who has been allowed considerable freedom at home chafes at the regulations regarding hours and late leaves of absence and resents the rules regarding physician-nurse and patient-nurse friendships. The timid girl adjusts herself well to the regulations, but is constantly anxious lest she fail or make some horrible blunder. The pampered girl finds all discipline cruel and unfeeling; the one who has felt rejected at home resents her superiors as harsh figures of authority and the regulations as evidence of continued rejection.

In addition, many students find themselves not as well prepared as they had believed for the dislocation in their personal lives. They have left behind their families and friends and substituted the realities of the ward for their previous carefree academic lives. It is not surprising that some students find their nostalgia so severe and their loneliness so great that they seek some excuse for returning home. Other students express their severe emotional disturbances by somatic symptoms, such as nausea and vomiting, diarrhea, amenorrhea, or intractable headache, and use these manifestations as a reason for withdrawal from nursing school.

In the early days of training, many students become anxious and depressed because of a sudden loss of personal orientation and because of overwhelming feelings of inadequacy and inability to meet the prospective responsibilities and program of nursing training. The loss of personal orientation occurs because of the sudden exposure to new ideas and attitudes, the stark realities of the hospital, and the varying standards and beliefs of the new classmates. The immature or sheltered girl is appalled by the grimness and by the absence of the romance she has always associated with nursing. Closer contact and better understanding of these realities of life and sickness may cause her to question the validity of her previous philosophy and standards. Often she may find herself confused and depressed because she has no new, wholesome philosophy to replace the old beliefs which she no longer can accept. Observation of her fellow students and discussions with them may lead only to greater confusion regarding her standards of real values and morality. Many students will not be disturbed by the initial impact of the realities of life as seen in nursing school, but some will be so upset that they develop a protective veneer of hardness and flippancy to conceal their underlying confusion. One girl summarized her disillusionment as follows: "I used to think life was pretty grand until I came into a hospital and saw it as it really is."

Acute feelings of inadequacy, with resulting anxiety and panic, are usually engendered when the student surveys the magnitude of her program and attempts to assimilate complicated study assignments of totally unfamiliar material. The timid girl who has always learned slowly becomes

frightened when she falls behind in the assignments that the more clever students seem to master without difficulty. The intelligent girl who has always led her academic classes becomes disturbed when she finds that she lacks manual dexterity and fumbles through practical work which other girls perform easily. The attractive young woman who has always charmed her way through school and life becomes anxious and fearful when she faces her first major failure because she is not measuring up to the strict scholastic standards of nursing school. The introverted student masters the theoretical material without difficulty, but becomes discouraged because she finds it hard to enter into a good nursing relationship with her patients, while less capable, but more extroverted students seem to experience no difficulty. Students of every type of personality pattern will have some problem of this nature with resulting feelings of inadequacy. Many students will arrive at an independent solution of the difficulty. Others will be so overwhelmed by anxiety and discouragement that they will drift on into chronic timidity and inadequacy or withdraw from school because they see no way of handling their difficulties.

There are many other types of emotional problems that arise during training.[1] Some of them have their genesis in home difficulties or in adjustment to the school situation, while others are due to conflicts over personal behavior and ideals. These latter problems are common to all young women, whether in nursing training, vocations, or college. Some may believe that student nurses should not be concerned with such trivial problems, but the fact remains that they are young, vigorous human beings with the usual interest in popularity, escorts, and pleasures. A fair percentage of emotional upsets during training will occur because of disappointments in love affairs, conflicts between nursing and marriage, or some type of disturbance in emotional relationships with young men. This interest in the opposite sex is normal, wholesome, and to be expected in girls of this age. Moreover, no practical way has ever been found to prevent it. Since these friendships are inevitable, the school should help

[1] See Torrop, *op cit.*

to keep them within proper bounds by providing social events and facilities for the students to entertain their friends.

The majority of girls prefer to entertain their friends in a sensible and conventional manner, but if there are no facilities for such recreation, other possibilities will be utilized. Alcoholic excesses and uninhibited behavior are most likely to occur when there is a paucity of other social and recreational outlets. In addition, such unwholesome activities are likely to occur in school situations in which the student is so overloaded with work and study that there is not enough time for the normal social activities of young women. The student, therefore, attempts to crowd as much pleasure as possible into the short time available and may indulge in undesirable behavior because of the feeling that another chance for fun will not occur soon.

These activities are not only destructive to the young woman, but also are sources of painful feelings of guilt and depression. From a mental-hygiene standpoint, concern over the student's personal life is not unwarranted because many of the emotional disturbances that arise during training have their origin in this field. Moreover, the changing attitudes and training of the American home and the constantly shifting standards of acceptable behavior of the present day have left many girls confused regarding personal values and ideals.

Case 4.—A freshman student nurse was referred because of emotional tension and instability and episodes of depression. She stated that she enjoyed nursing, but had these periods of emotional disturbance which interfered seriously with her work, and she could not understand why they occurred.

She was the youngest child, and when she was six years of age the parents were divorced because of the father's promiscuity and alcoholism. The girl had been a healthy, normal child before this time, but now she became shy and uncertain, being ashamed of her broken home and the absence of her father. Because of her feelings of shame and inferiority, she was continually trying to convince others that she was a worth-while person in spite of her unfortunate family situation. She felt that her social position was precarious and she made every effort to conduct herself in a highly moral manner so that she would not be pointed out as an example of the effects of a broken home. She was extremely orthodox in demeanor, dress, and choice of companions, and spent most of her time attempting to achieve social acceptance.

Her previous education did not meet the standards of the institution of her choice, and she had to enter a school where the educational requirements were lower and the cultural background of the students

was less desirable. After entering training, she discovered that the moral standards and the cultural interests of some of her classmates were unacceptable to her. When she found that many of her classmates did not conduct themselves according to her standards of morality and behavior, she alternated between feelings of tension and anxiety and attitudes of righteous indignation and resentment toward the other girls. She became aware that her attitude was based on the fear that others would suspect her of the same behavior and would reject her socially as an undesirable person. Whenever people made disparaging comments about nurses, she became nervous, tense, and depressed, feeling that her hard-won social acceptance was now being lost.

This girl had left a group of friends who accepted her fully and a smooth, easy way of life to enter the realities of nursing. She had numerous cultural interests, but nursing training had left little time for them. She resented the discipline of nursing training and the regulations regarding hours, and often thought of the time when she could do as she pleased, enjoy irresponsibility, and live a pleasant, placid existence. She often wished that she could return and somehow recapture this contented, care-free life.

After several interviews, the student decided that others would probably judge her on the basis of her own standards and behavior, and that it would be well to allow her classmates to regulate their own lives. It was also possible to relieve her feeling of inferiority. She gradually reconciled herself to her new, more mature and responsible life and took up again her former cultural activities, and her general attitude and condition improved markedly.

V

The constant presence of emotional problems in student nurses calls for the development of improved facilities for mental hygiene. Such a suggestion should provoke a reasonable question: Can psychiatric guidance be provided in these cases of personality disturbances without dislocation of the whole nursing program? The following case reports illustrate some of the problems encountered, the procedure followed in dealing with them, and the results of treatment.

Case 5.—A student nurse, in the third month of training, was referred to the psychiatrist because she was extremely shy and embarrassed, seemed tense and uncertain, took criticism poorly, and showed no initiative.

This girl was the eldest of four children and came from a farm home of few advantages. When she was eleven years of age, her mother died and the patient became the housewife. The father kept the family together, his sisters occasionally coming to the home to see that the children were supervised. The patient worked very hard, had no opportunity for social life and little time for study, and led a rather isolated existence. Two years before, she had left home and worked in a factory to secure funds for nursing training.

When first seen, she was unattractively dressed and her whole manner was characterized by shyness and timidity. She stated that she was miserable in training, believed that she was inferior to the other girls, and feared that she was doomed to failure. Her lack of home training and her isolated farm life had given her no opportunity to develop social and cultural graces, and she felt tense and uncertain in her contacts with classmates and teachers. Since she had worked long hours at home and had had insufficient time for study, she was uncertain of her intellectual equipment and basic training. In training school she isolated herself from the other girls, became apprehensive in the classroom when asked to demonstrate a technique, or burst into tears when corrected.

During the interview it was possible for her to examine the underlying reasons for her feelings of inferiority and inadequacy and to learn that they were not based upon fact. Various methods of study and ways by which she might become a more social person were discussed with her in detail, and she promised to make every effort to help herself. Although this interview did not explain her occasional hostility toward her teachers, it appeared that it had given her confidence and a new understanding.

Three months later she requested another interview. She stated that after the original conference she had gained confidence and her work had improved markedly. The other students, however, now found her arrogant, headstrong, and irritable. She had just completed her work on gynecology ward and she had had a difficult time on that service. She hated the work, the patients, and most of all the supervisor, who was somewhat abrupt and domineering. She then added, "Anyway, I never did like to work with or for women."

She then began to talk of her childhood, her work at home, and her pride in her housekeeping ability. Her greatest joy had been to be "the boss" and to make and enforce her own decisions in the home. When her father had called in a relative for consultation about the home or the children, it had infuriated her. She had become very possessive about her home and her father and had resented any interference. She stated, "All my life I've had a bunch of nosey aunts butting into my affairs and telling me how to do things."

After some discussion, she began to see that she was carrying this same attitude into training school. She had been either self-effacing, when she believed herself inferior, or belligerently aggressive and intolerant of direction or authority. She was able to see the origins of these feelings in her earlier life and could now understand that the gynecology supervisor and the patients were recipients of a hatred not really due to them, but actually directed toward previous environmental factors. Her further adjustment in training was uneventful and her work and adaptability were quite satisfactory.

Case 6.—A sophomore student nurse, aged eighteen, was referred in January because of a marked change in her personality since the previous September. Whereas she had been an outstanding student, she was now failing. She had become insufferable to her classmates because of her cynicism and sarcasm and was irritable toward the patients, and she seemed to feel that every one was against her. When first seen, she was antagonistic because she had been sent to a psychiatrist, but when she learned that the interview was confidential, she became coöperative and

frank. She stated that since the last September she had been unable to study because her attention wandered and a thousand unimportant thoughts came to her whenever she picked up a textbook. She found herself constantly daydreaming, uninterested, lackadaisical, and unable to apply herself to a task. Even the realization that she was on the brink of failure could not change her study habits. She felt irritable toward herself and every one else and admitted that she was impudent to supervisors and patients. This student was really desirous of becoming a nurse, enjoyed the work, and knew that she was intellectually capable of mastering her studies. She could not understand what was wrong with her.

In discussing her earlier life, the patient stated that her father was excessively alcoholic and was irritable and sarcastic toward her, always suspecting her of immoral behavior. Although she fought constantly with the father, she was devoted to him. In her home community she had been active in social affairs, had had many dates, had attended dances, and had usually been quite happy. Whenever she had come home from a date, however, the father had accused her of immorality and a violent scene had regularly ensued. Before entering training, she had believed herself to be in love with an unstable young man who was "wild," drank heavily, and was always in some serious difficulty. Although she had had many offers from more acceptable young men, she had become deeply attached to this individual. She did not know why she was so attracted to him except that she was desirous of "saving him." She had entered training, however, over his protests.

This girl was the elder of two children. Her brother was an active, alert, friendly boy who was regarded by the parents as the "apple of their eye." The girl believed that she was not the recipient of an equal and fair amount of affection. She longed for more parental security, was jealous of the brother, and was constantly striving to gain a place in the affections of the parents, especially of the father.

It soon became obvious, both to the physician and to the girl herself, that she identified her drunken boy friend with her alcoholic father and that much of her love for the former was really a substitute for the parental affection that she felt had been denied her. At this point she told how she hated to return to training school in September after the summer vacation, which had terminated in a violent scene with her suitor. He had threatened to lose interest in her if she did not stop training and marry him. After he had left in a rage, she had returned to training school, believing herself heartbroken and deserted by every one. She was especially humiliated because her classmates knew of her romance, and she was afraid that they would notice that she no longer received letters.

After a frank discussion, the patient became aware of the reason for her choice of a suitor and saw that instead of being deeply in love she was really attempting to compensate for her home situation. When this point was settled, she was able to agree that it was not mature or sensible to be guided by such childish choices and that a happy marriage could not be built on such an unstable foundation.

She voluntarily returned to the physician five weeks later and seemed very happy. She stated that her morose, daydreaming attitudes had disappeared, that she could study again, that work held a new interest, and

that she was now having dates and good times. Her grades had returned to their former high standard. This was substantiated by the nursing office.

The student then began to ask advice about her sarcasm and her habit of telling "tall stories" which enhanced and exaggerated her abilities and importance. She went on to mention her jealousy of her brother, her feeling of inferiority, and her constant struggle to achieve a sense of security. As she discussed these problems, she became aware that both the habits that troubled her were overcompensatory efforts to win prestige and to appear important and secure. She was able also to realize that her methods were only causing antagonism and not winning the security and admiration she desired.

Her further adjustment in training school was apparently satisfactory.

Case 7.—A student nurse, aged twenty-one, in her second year of training, was referred because of recurrent hysterical episodes and repeated bouts of illness which appeared to be due to psychological causes. During her first year, she had been frequently sent to a physician because of nervousness, dizziness, palpitation of the heart, and extra systoles. In February she had been hospitalized and had had a gastro-intestinal roentgenological series because of vomiting, which usually occurred under stress. A short time later, she had had an appendectomy, and in March she again had been absent from duty because of intractable vomiting. In April she had been emotionally depressed, had had numerous bouts of weeping, and had appeared emotionally unstable. She had "collapsed" on duty, but had been able to resume work in an hour. In November she had been examined again because of weakness, pallor, dizziness, and vomiting. In spite of these difficulties, the nursing-school faculty believed that she was a girl of considerable ability, although handicapped by lack of emotional control. During the first year she had led the class scholastically and had been elected president.

Examination disclosed a diffident and uncertain young woman who was, however, honest and coöperative. She realized that her illness was not organically determined, but was really due to an inability to accept responsibility. Recently she had been assigned to night duty and was fearful that she might make a wrong decision or be faced with responsibility beyond her capacity. In fact, she would not enter the room of certain patients who were seriously ill, fearing that she might find them dead or in such a critical state that she would be forced into some error of judgment. In addition, the night supervisor was new and frequently asked her advice in handling situations. This terrified the student because she knew how much depended on her decision, and she believed herself inadequate to meet the test. Whenever responsibilities accumulated, she cried hysterically, vomited, and was completely incapable of doing her work.

The patient was one of twelve children reared in an underprivileged home of low cultural standards. As she grew up, she was appalled at the standards of her family and yearned for greater opportunities. Her parents were strict and domineering, and none of the children were allowed to express an opinion. The girl was taught to be quiet, to realize her inferiorities and incapacities, never to do anything on her own initiative, and to be satisfied with her lowly station in life. Nevertheless, she determined to achieve some worth-while goal, although her early life

and the attitudes of her parents made her feel that any self-improvement was beyond her abilities. (It was not surprising to learn that the student's ambition was to nurse children in underprivileged families.)

After the mother's death, the patient worked and struggled to gain an education. Her father married an aggressive, nagging, and domineering woman and the student left home because of constant quarrels. During high-school years, her only clothing was faded "cast-offs" and her constant work precluded the acquisition of social graces. She felt ill at ease in the company of others and overwhelmed by her own inferiority.

During her first year in the nursing school, she made a desperate effort to succeed and to assure herself that she was not as inferior as every one thought. She was afraid to recite, to express an opinion, or to take responsibility, lest her incapacity become apparent. Later, she became attached to a young supervisor and regarded her as an adopted mother. She sought the supervisor's advice on everything, accepted her decisions without question, and became totally dependent on her. The supervisor had recently accepted another position and the student was left with a horrible feeling of helplessness. There was now no one to make her decisions and direct her activities.

As her neurosis became more severe, she avoided her classmates, dropped her friends, and remained in her room so that her instability would not be noticed. She sought excuses to resign from training so that she might seek a more humble and less responsible position. She realized, however, that she could not return to her family level, and so she remained at her work, reacting hysterically whenever responsibilities became heavy.

In the interview, the patient explored her assets and liabilities, her real and imaginary inferiorities, her present mode of life and her future prospects, and made several important decisions. During the next two weeks she put these resolutions into effect and found that her difficulties disappeared. She reported a complete change in attitude and outlook, and she had made several important steps toward friendships, self-reliance, and happiness. She stated, "A couple of days after I talked with you, I made a serious mistake. I thought I would see how 'facing the situation' would work, and so I went directly to my supervisor and told her what I had done and that I had no excuse to offer. Instead of bawling me out, she sat down and discussed how I had come to make the blunder and how it could have been avoided, ending up by saying that she had made mistakes herself and that she was confident that I would do better in the future. You will never know how that changed my whole attitude. It was so much nicer than it used to be when I would sneak around and dodge the head nurse so I could postpone my bawling out." Unfortunately, the supervisor will never know how much she did to help a frightened and desperate girl over a crucial period.

Four months later the nursing office reported that the girl was an excellent leader and one of their most reliable students. No further illnesses or hysterical episodes had occurred.

VI

The preceding case reports suggest that at last a method has been found that offers a solution to all problems of nurs-

ing training. Unfortunately, this is not true. There is no infallible method of dealing successfully with all the emotional problems that arise in nursing school. Any approach will have failures, because no amount of guidance or understanding will assure the adjustment of certain students of inadequate personality organization. Some will possess handicaps of such a degree of severity that no amount of assistance will enable them to reach the standards required of the present-day graduate. No program will make an intelligent, reliable nurse of a girl of dull intellectual endowment. Failure and severe emotional disturbances are inevitable when students of low intellectual caliber are thrown into nursing situations that demand initiative, intelligence, and knowledge.

Case 8.—A freshman student nurse came to the psychiatrist voluntarily because she felt in need of assistance. She was deeply depressed, felt hopeless of success in nursing school, and was contemplating suicide because the future seemed so gloomy. Her face was somber and drawn, and she wept frequently during the interview.

She was the youngest child and the only girl in her family, and had been pampered, petted, and protected by her brothers and adoring parents. She had always depended on other members of the family and formed no personal habits of self-reliance. During school years she became more uncertain, shy, and seclusive and learned to derive her emotional satisfactions in the home with her mother. This sheltered and dependent life augmented her feelings of inferiority and convinced her of her inability to make an independent adjustment. Her essay for admission on "Why I Want to be a Nurse" contained no mention of the real reason—namely, that she was aware of her immaturity and fear of the world and hoped that nursing training would make her a mature, self-reliant woman.

In nursing school she continued her previous pattern of reaction. She was shy, reserved, and timid, remained apart from her classmates, and was convinced that all the other girls excelled her in ability, intelligence, and personality assets. She observed the others attack tasks on the ward and in classes and constantly reminded herself that she could not equal their performance. She had no dates because of timidity in meeting others and spent her time alone in her room feeling lonely and inadequate.

During mid-term examinations she had a severe anxiety reaction and scarcely attained a passing grade. In the ensuing months this anxiety deepened into a depression, and she became unable to study or to concentrate on her duties. She longed for some face-saving excuse to withdraw from training and hoped that she would "catch something," injure herself on the ward, or have a nervous breakdown, so that she might return to the protection and solicitude of the home. She felt that she would rather commit suicide than return home and admit that she lacked the necessary stamina and courage.

Psychotherapeutic efforts were usually successful in producing considerable improvement for one or two days, but after this time the

depression would reappear. She had long bouts of self-pity because she was so forlorn and neglected, and occasionally she became resentful, believing that the faculty gave more assistance to other girls. She did, however, attempt to remedy some of the faults in her personality pattern and to achieve more scholastic success, but these efforts were short-lived. She developed a hypertension of 150/90 mm., and the internist could find no physical cause for it and believed that it was due to emotional stress.

This serious manifestation indicated that the student was injuring herself in what appeared to be a hopeless struggle. She was advised to enter a less stressful and responsible vocation, and she later adjusted herself more happily as a clerk.

VII

The aim of modern nursing educators should be to reduce psychological disabilities and casualties among student nurses to a minimum. This requires the formulation of a definite program and principles of management. The following suggestions may serve as a tentative scheme of approach.

Careful selection of students is of fundamental importance because any mental-hygiene program will have many failures if the trainees are chosen haphazardly. Admission to nursing school should be postponed until the girl is really certain that she wishes to be a nurse, and until it is evident that this is a mature decision and not merely the consummation of an adolescent fancy. This postponement of decision can be accomplished practically by requiring one year of collegiate education. This year allows the girl to survey other vocational fields before it is too late, adds to her maturity and poise, and gives her the opportunity to develop independence and self-reliance away from the protection of her family. Such a requirement may inflict an initial handicap upon smaller schools of nursing and upon girls with meager funds, but the end result will justify this added requirement.

The next requirement is a careful medical examination before the applicant is accepted as a student. All examinations should be made by the training-school physician and should include a study of the student's emotional reactions to the situation. The physician must be interested in the training-school problem and must not let the examination become cursory or routinized into the mere completion of health forms. Each examination must be individual and held out of hearing of other applicants. This will encourage frankness and will permit the applicant to ask questions and to

volunteer information or to discuss any emotional reaction that may appear during the examination. If this study discloses considerable emotional tension, the applicant should be interviewed by the staff psychiatrist.

This preliminary sifting will not reveal all the emotionally unstable applicants. A careful examination by an interested physician, however, will disclose a number of individuals with personality disturbances. Some of these will be so severe that the applicant will be doomed to failure if admitted to nursing school, while others will be of a lesser degree and will mean only that this student needs careful management and may possibly require special assistance. Even if the applicant is defensive and guarded in her responses, her behavior during such an examination may reveal an underlying personality problem.

Case 9.—Physical examination of this applicant was completely negative. The girl, however, appeared to be quite shy and retiring, and the examining physician made a careful inquiry into her health history. Finally the applicant asked if there was any treatment for "falling and paralysis due to emotional excitement." Further questioning revealed that three years before, while laughing heartily, she had suddenly fallen to the floor and been momentarily paralyzed. Since that time, she had had recurrent periods of uncontrollable drowsiness, which were relieved by a few moments of sleep. The episodes of paralysis were also recurrent and were precipitated by any powerful emotion of fear, anxiety, or joy. The patient had learned to shield herself from all emotional situations and to remain apart from others to avoid stimulation. But the attacks of paralysis and drowsiness had persisted for three years whenever she experienced any powerful feeling.

Neuropsychiatric examination did not reveal any organic disorder of the nervous system. There was a complicated family situation caused by an ambitious, domineering mother and a clever, more attractive sister, but it was not clear whether this difficulty had any connection with the patient's problem. It was apparent, however, that this girl had "narcolepsy and cataplexy" and that she would continue to have periods of falling and weakness under the stress of emotion. She was not accepted as a student since it was obvious that she would necessarily be exposed to repeated emotional situations in training school. In this case the hospital and nursing faculty were spared some distressing episodes, and the girl was saved from the humiliation of dismissal, by the alertness and interest of the examining physician.

The next requirement in a preventive program should be a good intellectual endowment and learning aptitude.[1] These abilities should be evaluated by psychometric and nursing-

[1] See "The Value of Psychological Testing," by Esther Brooks. *American Journal of Nursing*, Vol. 37, pp. 885–90, August, 1937.

aptitude tests because scholastic grades are not always a reliable indicator. It has been shown that failure in nursing school is the usual fate of students of low mental caliber, and a difficult and stressful training period is inevitable if the student is of border-line intellectual endowment. The scholastic pace of modern schools of nursing is rapid, and the less intelligent girls find themselves falling behind in spite of their best efforts and invariably react with anxiety and tension. Indeed, there is no better way to produce an emotional disturbance than to demand that an individual cope with a situation beyond his capabilities. Applicants of low intellectual endowment should not be accepted for admission. This will save many girls the anxiety and depression of a hopeless intellectual struggle and the humiliation of dismissal.

The orientation program is another excellent development to promote intelligent selection of students and to facilitate their adjustment to the school. This period before acceptance provides valuable information regarding the applicant's emotional reaction to the environment and her adaptability to a new routine and associates. It is valuable from the mental-hygiene standpoint because it gives the student a gradual acquaintance with a new situation, warns her what may be expected, and still provides an opportunity for a graceful withdrawal if she does not like the realities of nursing. The program should be carefully planned to present a realistic picture of the training-school program and duties.

After a student has been admitted to school, every effort should be made to facilitate her adjustment. This should include adequate opportunities for recreation and for social activities. Cultural advantages should be made available to increase the student's poise and understanding and to balance the preponderantly scientific curriculum. Such a program will not be feasible in a practical sense if the student is so overworked that she has neither time nor energy for these activities. There is little value in providing recreational and cultural facilities to a student who is already exhausted by her daily program.

In some instances the educational program and system of ward assignments may be factors in the production of

unwholesome attitudes in the student nurse. Whenever any individual enters a new and difficult life experience, there is usually anxiety and tension due to fear of inadequacy and failure. If the individual is desperately anxious to succeed and somewhat fearful that the situation is beyond his abilities and knowledge, he will usually respond either with overcompensatory arrogance or with blundering reactions born of panic. This is exactly what happens when a student nurse is given responsibilities or duties for which she is not adequately prepared. Repeated embarrassing failures destroy her self-confidence. A harsh reprimand or sarcastic comment from the supervisor at this time only reinforces the student's feelings of inadequacy and depression and may produce severe demoralization.

The personality of some of the faculty and supervisors may also be a factor in the production of emotional disturbances in the students. It is possible for a faculty member to be intelligent and thoroughly trained in her field and yet not to possess the qualities necessary in a teacher. Some teachers may have unfortunate personality attributes which inspire resentment, and others may lack the emotional control and poise necessary for dealing with young women. If an appreciable number of previously fairly well-adjusted students develop emotional problems or unwholesome changes of personality in the same class or ward assignment, it is possible that the psychological difficulties of the teacher may have been the etiological factor. In some instances the real fault may lie with the nursing administration which has placed so much responsibility and pressure upon the supervisor that she vents her irritability, weariness, and discouragement upon the students. The nursing faculty should have the courage to examine themselves regularly to ascertain if they are responsible for the creation of emotional and behavior problems. This suggestion does not mean that the student should be cushioned against all the adverse and unfair realities of life, but at least she should not be subjected to undue pressures because of the personality difficulties of her teachers.

The most practical method of promoting student mental hygiene is the provision of direct guidance and counseling facilities. In some schools this has been attempted by assign-

ing a certain number of students to each member of the faculty for advice and guidance. Such a program is usually unsuccessful because of certain practical difficulties. Many excellent teachers are either not interested or not capable of participating in such a guidance program. Some have personal characteristics that make it impossible for them to assume such a guidance relationship with the student. In addition, their authoritative faculty positions, their supervision of grading, and their disciplinary functions preclude full confidence on the part of the student. As a matter of fact, in an interview the student's first question usually is, "This won't get to the nursing office, will it?"

The inadequacies of this system necessitate the organization of an improved guidance program. The key individual in such a program should be a psychiatrically trained nurse of sympathy and understanding who would act as student counselor. The professional qualifications for such a position should be strict. In addition, this individual should be a sensible, experienced woman who is "old enough to be mature, young enough to understand." Above all, she should possess critical judgment and an appreciation of her limitations and know how far to go in her guidance activities. She should have a faculty appointment and should attend official meetings. She should not, however, have teaching responsibilities (except possibly for some psychiatric course) and should not be associated with student grading or evaluation or disciplinary actions. Although she would not be able to protect a student from faculty discipline or action, her advice in executive meetings could be of value, without the disclosure of confidential material.

This counselor should have a room in the residence, should be easy of access, and should have sufficient time to deal adequately with the problems and questions of students. The keynote of her work should be to maintain the friendship of the girls and to preserve their confidences. She could give common-sense advice and act as a mature friend with whom the student could discuss any type of problem in confidence. A psychiatrist should be available to handle the more complex problems and, working in conjunction with the counselor (and through her with the nursing faculty, the social and recrea-

tional director and so on), could plan remedial procedures. In those instances in which an adjustment is impossible because of intellectual handicaps or emotional difficulties, the blow of dismissal might be softened and the student helped over this trying period into other vocational programs.

Both the counselor and the psychiatrist are under an ethical obligation to respect the students' confidences. There is also, however, an obligation to the nursing school and the public, and the guidance counselors must use judgment and common sense. If the student's mental condition constitutes a source of danger to herself, to the nursing school or hospital, or to the public, it is not a breach of confidence to protect all concerned by appropriate measures.

This plan is not a proposal to shield the student from the faculty or to enable her to escape the obligations and responsibilities of nursing training. It does not promise to make a nurse of any girl, regardless of her handicaps. It should not be used as a method of protecting and sustaining through training school a student who does not possess the necessary qualifications for meeting the responsibilities of a graduate. Rather, the function of a mental-hygiene program should be to assist the student nurse in her adjustments, to minimize her emotional conflicts, and to facilitate her achievement of maximum wholesomeness with the greatest possible utilization of her latent capacities.

THE PSYCHOLOGY OF THE ADOPTED CHILD

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THE child who does not grow up with his own biological parents, who does not even know them or any one of his own blood, is an individual who has lost the thread of family continuity. A deep identification with our forebears, as experienced originally in the mother-child relationship, gives us our most fundamental security. The child's repeated discoveries that the mother from whom he has been biologically separated will continue to warm him, nourish him, and protect him pours into the very structure of his personality a stability and a reassurance that he is safe, even in this new, alien world.

Every adopted child, at some point in his development, has been deprived of this primitive relationship with his mother. This trauma and the severing of the individual from his racial antecedents lie at the core of what is peculiar to the psychology of the adopted child. The adopted child presents all the complications in social and emotional development seen in the own child. But the ego of the adopted child, in addition to all the normal demands made upon it, is called upon to compensate for the wound left by the loss of the biological mother. Later on this appears as an unknown void, separating the adopted child from his fellows whose blood ties bind them to the past as well as to the future.

It is pertinent never to lose sight of the fact that no matter how lost to him his natural parents may be, the adopted child carries stamped in every cell of his body genes derived from his forebears. The primitive stuff of which he is made and which he will pass on to future generations was determined finally at the time of his conception. Neither genetists nor psychologists know enough to disentangle the mosaic weave of the personality and say, "This trait is hereditary," or, "That is purely the result of identification." Every per-

sonality manifestation is an expression of the response to present environmental situations of what we are by heredity, and by our earliest experiences and identifications. Presumably the degree of libidinal strength, or insistence upon direct instinctual satisfaction, is constitutionally determined, as to some extent is the capacity of the ego to defend itself economically.

Environment, or experience, influences the personality in very different ways, depending upon the age and maturity of the individual. Those experiences and emotional relationships which exist in earliest childhood have effects that are incorporated into the very structure of the personality. Experiences and relationships after the Œdipal development may mold or modify the presenting or external personality, but their effects are as a general rule not incorporated or built into the personality. It may be said that the external environment functions in two capacities. In the earliest years, it combines with constitutional factors to determine personality. Later on, through the influence of education, environment and experience modify personality manifestations, even to the extent of creating the person we think we know. Though analogies are unsatisfactory, we might say that, in the construction of the personality, constitution provides the basic metal, infantile emotional relationships and experiences add alloys and temper the metal, and childhood education and environment provide the superstructure, the façade, and the paint.

The implications of this for the psychology of the adopted child are of the utmost significance. The child who is placed with adoptive parents at or soon after birth misses the mutual and deeply satisfying mother-child relationship, the roots of which lie in that deep area of the personality where the physiological and the psychological are merged. Both for the child and for the natural mother, that period is part of a biological sequence, and it is to be doubted whether the relationship of the child to its post-partem mother, in its subtler effects, can be replaced by even the best of substitute mothers. But those subtle effects lie so deeply buried in the personality that, in the light of our present knowledge, we cannot evaluate them.

We do know more about the trauma that an older baby

suffers when he is separated from his mother, with whom his relationship is no longer merely parasitic, but toward whom he has developed active social strivings. For some children, and in some stages of development, this severing of a budding social relationship can cause irreparable harm. The child's willingness to sacrifice instinctive gratifications and infantile pleasures for the sake of a love relationship has proved a bitter disillusionment, and he may be loath to give himself into a love relationship again. We also have reason to believe that if an adoption placement is made in earliest infancy with parents who accept and love the child, there is the maximum probability that the child's emotional and social development will parallel that of the own child, even though the adopted child has had to forego infancy's first and greatest protection from tension. The child who is placed in infancy has the opportunity of passing through his Œdipal development in relationship to his adoptive parents without an interruption that, in the child's phantasy, may amount to the most severe of punishments. The child who is permanently placed within the first month or two of life may be influenced in the roots of his personality by his adoptive family. His primary identifications will be with his adoptive mother and father. The earlier in life a child becomes a part of a family, the more deeply can that family become a part of that child.

Although the adopted infant obviously cannot experience fully with his substitute mother the satisfactions of the nursing period, he will experience with her his first and supremely important socializing relationship. The process of receiving food or sucking is for the infant at first an intensely personal experience, but through it the child establishes his earliest meaningful rapport with another individual. If his first social relationship is satisfying and free from tension, his later social relationships will be easier for him. If his feeding experiences in infancy consist of one battle after another, he is apt to go battling through life, tense, suspicious, and anxious over social relationships.

The child who, before being placed for adoption, has lived in an institution or a foster home has been profoundly influenced by his feeding experiences. Babies cared for in institutions are usually fed by a number of different nurses or

attendants who are more interested in getting correct amounts of formulæ into their charges at specified times than they are in the infants themselves. Some institution babies are even left alone in their cribs to suck from a bottle propped on a pillow. These children lose their earliest and most important opportunity to establish an object relationship through which they can progress from the stage of primitive narcissism to that of socialized human beings.

The infant who is placed in a boarding home preliminary to adoption does live through some sort of socially influencing experience in relation to his foster mother, but, because of the very fact that the home has deeply influenced his ego development, the interruption of his relationship with it is traumatic.

The following case is one that shows very clearly the traumatic effect of an ill-advised adoption on a boy whose social and emotional development was tied up with a previous foster-home placement.

Dan is a nine-and-a-half-year-old boy, who was adopted at the age of three years. He was referred to a children's study home because of running away, bunking out, and a devastatingly negative, hostile reaction to his adoptive mother. Dan ran away only when his adoptive mother was at home. He never ran very far, but rather than come home, he would endure untold hardships and discomforts. On one occasion, in the dead of winter, he stayed out for several nights, and when the police found him, his legs were both badly frozen.

From the time he had first come into the home, he had always been negative, especially with the adoptive mother. He avoided her as much as possible and seemed annoyed when he had to speak to her. On some occasions, when his mother was at home, he would refuse to eat in the dining room with the family, but, instead, took food from the ice box to eat in the privacy of his room. At times, and for no obvious reason, Dan burst into tears which he could not explain any more than he could explain his bizarre running away. On one occasion, when he was asked about his running away, he said that a feeling came over him "like a threat."

Dan's adoptive mother compared him unfavorably with her other adopted boy, who was of the same age, but who had been in the home since infancy, three years longer than Dan. This rejection on the part of the adoptive mother added fuel to Dan's fire of hate. The adoptive mother had originally taken Dan in order to give a companion to the other adopted boy—not the best motive for adoption. However, Dan's immediate life situation in no way explained his behavior. The home was a good one and offered all the satisfactions that a boy would need. The adoptive father was an exceptionally fine person, and the adoptive mother, although tense and neurotic, was kindly and well-intentioned. The adoptive brother was making an adequate adjustment and was

devoted to Dan. For the key to Dan's behavior, we have to go back to the story of his adoption and his life prior to that fateful event.

When we review Dan's history, we gain some understanding of the problem he presented. He was an illegitimate baby who, at the age of three weeks, was placed by his mother to board. He remained in this foster home for three years, until his adoption took place. In the foster home, he was the baby of the family. There were two children very much older than "Sonny," as Dan was called. The foster mother had lost several other children in infancy, and she accepted Sonny completely as her own baby. He was the adored baby of the entire family, even of the neighborhood. For three years he lived in that home and held the center of the stage. The foster mother was a warm, motherly, affectionate person, and it is said that when they parted with Sonny, both the foster mother and the father felt the loss as if it had been the death of their own child.

While living in the foster home, Sonny was visited periodically by his own mother, whom he spoke of as "Mummie Kay." She, too, was "a good mother" to him and brought him frequent gifts. During these three years, Sonny was apparently an outgoing, happy child, developing normally.

When arrangements for the adoption were made, the foster parents were loath to lose their baby, but felt that in the adoptive home he would have far greater educational opportunities than they could hope to give him. They did not wish to upset him by telling him that he was to leave home, so he was told one day that after his nap he was to go for a drive with a friend of "Mummie Kay's." Sonny complained that he did not want to go, but would prefer to play at home with "Mummie" (his foster mother). However, after his nap, when the big automobile drew up at the house, Sonny climbed in full of enthusiasm for a ride in the car with the nice new lady. He was driven away and has had no contact since with either of his foster parents or with "Mummie Kay." One can imagine what a terribly traumatic situation this must have been for a three-year-old child whose entire world revolved around his love objects.

When Dan arrived in his new home, he showed a typical childish absence of an expected mourning reaction. It is likely that Dan's sorrow at the security he had lost was so great that his immature ego could not face it and his sorrow was, therefore, entirely suppressed or denied. Dan repressed all memories of his first foster home. In his unexplained outbursts of crying, he is now giving evidence of a deferred mourning reaction. He cries, but he does not know why or for what he cries. It may also be that in his symptom of running away and hiding, he is repeating, in a distorted form, the traumatic situation to which he was subjected at the age of three. He comes back from his expeditions in such a condition that he has to be put to bed and lovingly cared for and nursed.

Any child who is placed for adoption after a preliminary temporary placement is deprived, not only of the primary security of an intimate relationship with his own biological mother, but also of a completely experienced infancy with his adopted mother. The period of toilet training (approxi-

mately the second and third years of life) carries on as a natural psychological sequence the process of socialization that began in the nursing period. Because of the love the baby has come to need to receive from his mother and to give to his mother, he accepts his first responsibility in life—namely, toilet training. He gives up infantile sources of pleasure for the sake of his mother, whose love he wants to hold and whom he wants to please. The child who lacks the motivation of a growing social and emotional relationship with a highly valued love object does not accept training in a spirit of coöperation. If he accepts it at all, it is likely to be in response to fear of the consequences of wetting and soiling. Many children use persistent wetting and soiling as a method of expressing their antagonism to a mother with whom they have not experienced an early, satisfying love relationship.

Toilet training should not be superimposed upon a child whose satisfactions in life are still essentially unsocial or in the service of aggressive impulses. A child whose earliest education or training was entered into as a coöperative enterprise, under the influence of a love relationship, faces later education and life in a different spirit from that of the child whose first training was forced upon him from an impersonal, outside world, or by an individual to whom he was not yet tied by bonds of love. Children placed for adoption after the nursing period must be won into a love relationship before they are asked to make the sacrifice of giving up infantile pleasures and accepting training. The ego of the child who is placed during or after the training period has been deeply influenced both by his nursing and training experiences and by the personalities of the individuals with whom he lived through these experiences.

Brisley[1] points out that the illegitimate baby (and this usually applies to the prospective candidate for adoption) is under abnormal pressure to "be good." This implies first being quiet and taking feedings well and, later, accepting toilet training at an early age. This emphasis Brisley suggests is "a contributing factor to the insecurity and feeling of aloneness which seems to us characteristic of the illegitimate child."

[1] See *The Unmarried Parent-Child Relationship*, by Mary S. Brisley. New York: Child Welfare League of America, 1939.

The structure of the child's ego is susceptible to influence from the outside world only so long as the child is capable of forming identifications with love objects and only so long as his patterns of ego defense are not firmly entrenched. Ego defenses [1]—such as repression, regression, reaction formation, isolation, undoing, projection, introjection, turning against the self, reversal, and sublimation—are established—but not inevitably finally fixed—during the period of childhood that terminates about the fifth, sixth, or seventh year. Since the ego defenses are the personality as we see it in operation, we can recognize how important it is that the adoptive home be the home in which the development of the ego and the super-ego takes place. The degree of tolerance or intolerance with which substitute parents—be they nurses, foster parents, or adoptive parents—accede to or prohibit gratification of instinctual impulses conditions the compromises or defenses that become such an important part of the child's personality.

The child who has already had environmental experiences and who has had to face traumatic situations comes to the adoptive home with unknown patterns of defense as well as with the inevitable unknown factors implicit in being separated from his family antecedents. This child's normal compulsion to repeat old patterns will include the repetition of reaction patterns foreign to the patterns of the family that is trying to assimilate him. It must be remembered that all the situations that child-guidance clinics find as etiological factors in producing behavior or personality problems in own children can play a significant rôle in the case of the adopted child. This is true whether these situations are present in the adoptive home or whether they are still active in the child because of his past, even forgotten, experiences. The traumatic factors to which I allude include such things as overprotection, rejection, overindulgence, emotional neglect, sibling rivalry, parental discord, insecurity, and so on.

For the adopted child there is always a question to which he can find no answer in the world of reality—even when every question he can frame is answered with full sincerity. The adopted child, more even than the own child, needs the

[1] See *The Ego and the Mechanisms of Defense*, by Anna Freud. London: Hogarth Press, 1937.

security of a firm foundation in the love of the adopted parents. More than the own child, he needs the deep reassurance that he is accepted and loved by his adopted parents. To protect himself from his basic anxiety, the adopted child may even create outrageous situations that will force his adopted parents to prove their love for him and their wish to have him for their own.

Felicia, the child adopted at two-and-half years in Honoré Willsie Morrow's recent book, *Demon Daughter*,[1] can serve as an example of many aspects of the psychology of the adopted child. Felicia's whole childhood and adolescence is a confused striving for aims she never grasps and cannot verbalize. Symbolically, she expresses her tortured dissatisfaction and her unconscious loneliness in her efforts to find the elusive "happy prince," whom she later names "the lonely prince." Her phantasy that she must find the "lonely prince" (and thus know the answer and achieve the happiness of security) leads her into outrageous situations with a series of boys that sorely try the sympathetic and enduring love of her adoptive mother.

Every child, whether living with his own parents or with foster parents, has recourse to phantasy when he finds himself frustrated, threatened, or incapable of dominating his environment. A common phantasy which most of us can remember from our own childhoods, and which we find universally expressed in our hero myths, is that which analytic literature refers to as the "family romance."[2] According to this phantasy, the parents with whom we live are not our real parents. Our real parents belong to the nobility or are fabulously rich or famous. Because of some mystery surrounding our birth or some prophecy concerning our future, we had to be separated from our parents and brought up by the quite common people whom we know as mother and father. As the phantasy—or the myth—is elaborated, we, by our own goodness, prowess, and courage, derived from our noble heritage, overcome all manner of difficulties and finally achieve the status in life to which we are obviously entitled.

[1] New York: William Morrow, 1939.

[2] See *Myth of the Birth of a Hero*, by Otto Rank. (Nervous and Mental Disease Monograph Series No. 18). New York: Nervous and Mental Disease Publishing Company, 1914.

Children living secure in the love of their own parents can indulge in this phantasy as in a game. The reality satisfactions from flesh-and-blood own parents, ever close at hand, drive the phantasy into the storerooms of the mind, to be enjoyed upon occasion, but not taken too seriously and certainly not to be acted on as reality. For the adopted child it is not a phantasy that these parents with whom he lives are not his own parents—it is reality. He actually has two sets of parents—or more if he has experienced foster-home care. For him there is a real mystery as to his antecedent possibilities, and correction of the foundling phantasy by reality is much less likely than in the own child. Felicia, the "demon daughter," did try in disguised forms to live her phantasy. Her adoptive mother, no matter what course she pursued, seemed to Felicia to stand between her and happiness—or what she deserved—as represented by the shadowy, elusive figure of "the lonely prince." At one point in the book, Felicia in all seriousness tells a young man that she is the illegitimate daughter of an English duke.

The background for the creation of the "family romance" lies in the normal ambivalence of the child toward his parents.[1] The child solves his ambivalence conflict by creating for himself a second set of parents on whom to focus his hopes and his love during periods when his real parents are failing him or disappointing him. For the adopted child, the second set of parents are obviously the unknown, lost real parents. His normal ambivalence will make use of his reality situation to focus his love impulses on one set of parents and his hate impulses on another. He finds an easy escape from the frustrations inherent in his home education by assuming the attitude that these, his adoptive parents, are his bad and wicked persecutors, whereas dimly remembered own or foster parents, from whom he was "stolen," are represented in his phantasy as the good parents to whom he owes his love and allegiance. In the case of Felicia and in that of Dan, already presented, we see clearly the important rôle played in personality formation by phantasies associated with the unknown, mysterious status of being adopted.

[1] See "On the Genesis of the Family Romance," by Helene Deutsch. *International Zeitschrift fur Psychoanalyse*, Vol. 16, pp. 249–53, 1930.

HAPPINESS IN OLD AGE

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TALLYRAND, the French statesman, is reputed to have said: "Every one wants to live long, but no one wants to be old." This is a very challenging remark. Curious to test its truth for ourselves, we recently approached through questionnaires and interviews a group of about fifty older people. Their average age was sixty, although a number were in the eighties, and one went as high as ninety-one. To this group, two-thirds of whom were women, we put the question:

"If you could press a button and exchange the satisfactions that you have to-day for those you enjoyed in your youth, would you press this button? In other words, balancing the good against the bad to-day, and the good against the bad when you were young, which time of life would you choose, if you could?"

We cannot report any clear-cut decision. Some were happier in old age, because they had known a miserable and difficult youth, and now were economically secure, in improved health, and so on. Others who preferred 1941 to 1901 were the kind who had always found life good, and who saw nothing amiss with their present situation. As one of these said, "The time to be happy is *now;* the place to be happy is *here.*"

Many people started out by saying that they were just as happy now as they were when younger, if not happier. But as they spoke, something happened. Bit by bit came the reluctant admission that youth was a happier time. This was especially true with those of the more advanced ages.

Whether or not those who said they preferred their youth were really happier then, is, of course, open to question. Certainly adults are prone to exaggerate the joys and to minimize the troubles of young people. An older person who is unhappy to-day is apt to forget that he may have been even more unhappy forty or fifty years ago. There is a

great deal of truth in the observation that youth would be much more interesting if it came later in life.

As might be expected, the answers to this question whether one would exchange an older life period for a younger one threw a good deal of light on the satisfactions and discontents of the senior years. We have ranked these according to the frequency with which they were cited:

ASSETS AND LIABILITIES IN LATER LIFE

On the plus side:

1. Good health.
2. Trust in God.
3. Cheerful state of mind.
4. Money.
5. Friends.
6. Gainful occupation (or the equivalent in interesting and useful activity).
7. Pleasant relationship with members of one's family.
8. Contemplation of one's children and grandchildren.
9. The satisfaction of doing things for others.
10. Kindly treatment from others.

On the minus side:

1. Ill health.
2. Lack of religious belief.
3. Lack of emotional discipline—*i.e.*, poor childhood training in the way of meeting hardship and disappointment.
4. Lack of money.
5. Lonesomeness.
6. Absence of occupation and interests.
7. Self-centeredness.
8. Unkind treatment from others.

In most later-life inventories, health is given first place. Painful illness is not welcomed, of course, but it can be endured. What is dreaded is the possibility of being helplessly bedridden for a long period. That is why pneumonia, in the pre-sulfanilamide days, was called "the old man's friend"—it offered such a quick and painless exit. The fear of being disabled is greater even than the fear of death, which is seldom expressed and, so far as conscious awareness goes, seems to decrease rather than increase with the late years.

Our results underscore the recommendation that all persons, regardless of financial means, should receive adequate medical care, as well as thorough physical examinations at regular intervals. Moreover, our physical and mental needs

change with age. We must, therefore, modify our routine in the way of diet, living habits, amount of rest and recreation, and so on. In the second half of life, it certainly is true that every one has become either a fool or a doctor.

If health of the body is essential to happiness in late maturity, then health of the spirit is a close second. Again and again did those whom we interviewed show that one of the most regular and striking accompaniments of aging is the increased hunger to explain our lives to ourselves, to discover some justification for the world and for human nature as we have found them. Some persons in our group favored institutional and organized religions, others had a private and purely personal faith. For example, a woman of sixty-eight reported: "When I have accomplished the seemingly impossible, I have recognized the fact that any strength and accomplishment come from God, even though I was and am a member of no church and never attended service." And a man of eighty insisted: "A belief in God is necessary if one is to be really happy. It is something that is strong, that gives strength, and that no one can take away from you."

An item often cited as essential to the well-equipped older person is a cheerful state of mind. This means a willingness to accept what we cannot alter, to be patient with those whose opinions we cannot share or whose behavior we do not choose to imitate. Many older persons live on an income without suspecting it, but it is an income of painful recollections. Such men and women might consider well the saying: "The happiest person is the one who has the most pleasant memories."

Surprisingly enough, money appears fourth among the sources of contentment in later life. Not that these folk despised money. Indeed, most of them felt that the lack of it was a great inconvenience, to say the least. But they also had learned that money alone could not purchase happiness. All that concerned this group was the wherewithal for obtaining necessities. Money as "wealth" or as "luxuries" was a relatively minor matter.

Two-thirds of Americans at the age of sixty-five have no funds and are dependent either on relatives or on the government for support. It is, of course, true that we ought to have a nest egg set aside for our old age. It is also true

that inadequate salaries, illness, unemployment, unfortunate investments, family emergencies—any or all of these may prevent the accumulation of a nest egg or destroy the one we have. Hence, financial security is something that the individual in a modern industrial civilization cannot himself solve completely.

"Friends, few, but loyal"—this was an oft-repeated phrase. For the longer we live, the more friends we manage to survive. And even when our friends live as long as we do, one thing or another may make them unavailable—sickness, perhaps, or infirmity, or removal to some distant place, or it may be just a gradual and unexplained drifting apart. In view of this, our "interviewees" felt that we should try to start adulthood with as many friends as possible. Then, when we reach our thirties and forties, we should not only maintain and salvage old friendships, but start new ones to replace casualties. Making new friends is difficult as we grow older. Yet those persons are best adapted to old age who have kept in good working order their curiosity and adventurousness, whose appetite for new experience has been neither dulled by oversatisfaction nor killed by starvation.

Age, for most persons, means a reduction or a cessation of employment, because of ill-health, retirement, inability to obtain a job, and so on. Those who cannot either find a substitute for their former occupations or accept the retarded tempo of their new daily routine are headed for trouble. Here, for example, is Mr. X, eighty-two and disgruntled. All his ideas of happiness have to do with activity—being busy, accomplishing things. "Working hard, playing hard, loving hard," he protested vehemently, "that's what makes people happy." But he has been forced into an inactive life, although on a pension. Says our octogenarian, "My family, instead of giving me little things to do, pamper me, treat me like a favorite piece of china which is *just* too fragile for words."

Family life is always with us. In some cases, it could hardly be called an aid to our pursuit of happiness. In other instances, the warmth and intimacy among close kin is something beautiful to behold. A large family, strong and united, fortifies the individual against the onslaughts of fate. Those in our group who had enjoyed contacts with relatives felt, as

the years went on, like trees stripped of leaves and branches and left to face the elements unprotected.

To watch our children grow and develop, establish themselves and be happy, and then give us grandchildren who grow and develop—all this is a necessary ingredient to the happiness of many older people. Said a woman of seventy-five: "It gives a person a sort of satisfaction to feel that these grown people are flesh of his flesh and blood of his blood. It makes him feel that living was not in vain; that when he died, he did not altogether leave this world." And a woman of sixty-five sorrowfully exclaimed, "All of my sorrow and all of my happiness comes from my children."

To grow old is in many ways like having some one apply a magnifying glass to one's personality. The longer we live, the more like ourselves we become. Those who are isolated and self-centered in youth tend to become even more withdrawn. Those who always found pleasure in doing things for others feel more keenly the need of being as helpful as circumstances—and other people—permit.

Trying to be of service to those around us is important because it bolsters up our sense of belonging. If there is one great gift that the aged can give the world, it is generosity and selflessness. Perhaps only they know the meaning of Charles W. Eliot's statement: "What do we live for, if not to make life less difficult for others?" This was supported by a man of fifty-nine who said: "Getting old is not in and of itself anything to be sorry for. It is only those people who have done nothing for the good of others who abhor oncoming old age and all it stands for."

We all want a place in the world as long as we live. Though some older persons are colossal and insatiable egotists, most are modest in their demand for attention. A number said that all they sought was ordinary kindness and consideration. But that is what they seldom received. We greet the aged either with cotton wool or with armor plate, either with excessive solicitude or with stony silence.

One thing that we learned from this little study is that the word "happiness" shifts its meaning for us as we grow older. If you think of what constitutes youthful happiness and then ask whether old age is happy, expecting to find the same

experiences and satisfactions as in youth, you will say that old age cannot know happiness, since these experiences and satisfactions will be absent. In youth, happiness means freedom from care and responsibility; it means gayety and going out with members of the opposite sex; it means setting goals and achieving them; but most of all it means activity.

Said a man of sixty, "Happiness in the younger years is a happiness of expectation, of hope, of desire." And a woman of fifty further explained: "Young people are happy in doing, while older people are happy in seeing others do." In later life, then, the elements of happiness are health, religion, contentment, economic security, acceptance by society, and so forth—all in all a much more passive and contemplative existence, well summed up by a jolly old man of eighty-five: "Happiness in the older years is found only by an acceptance of the situation and making the best of those things which are pleasant and enjoyable."

It was this same man, once a gay and daring Beau Brummel, who lamented the fact that he no longer had the desires and consequently the pleasures that he had had when he was young. But it was a woman of seventy who saw the situation of some older people in its most poignant terms: "Happiness in old age is, in a way, a happiness of left-overs. Older people get happiness out of very little things. They squeeze it in little drops out of anything they possibly can. This is necessary, for it is these little drops that help them to live. These drops are, in a sense, their life's blood."

The well-adjusted older person "renders unto youth those things that are youth's, unto age those things which belong to age." He enjoys the experiences that his particular age makes possible, neither concerning himself about those that lie ahead nor holding on to those that he has left behind. Happiness, after all, does not consist of particular possessions or events in one's ilfe, but rather of the *method* with which we meet all experience.

To return to our original question, probably most of the persons in our group would say: "Yes, I want to press the button that will turn back the clock for me." Perhaps when we try to audit the 1941 ledgers of these men and women, we will find a balance of pleasure and pain that is less favorable to them than in the faded books of 1901. But, from the

practical standpoint, is this finding so important? Isn't the crucial question something quite different, namely: "Are the discontents of old age the unavoidable penalty of living too long? Can they be lessened by such agencies as medical science, social reconstruction, or plain prayer?"

It may be that among these older people who helped make this study possible there were some who felt that any one who wished another person a long life was no friend. Others would have agreed with a woman of one hundred and three who regretted the prospect of death for only one reason—it meant leaving "this great, big, beautiful world."

This writer recognizes that growing old is fraught with many perils and discomforts, but he is not convinced that these are all as inevitable as doom. If we devoted to the problems of later maturity the same thought, social imagination, and well-directed effort that we have given to the problems of children, it might be possible to bring about a happier old age for the many millions now in their early or middle maturity. If that should happen, people might be willing to make two wishes—one to live long, the other to grow old.

THE PSYCHOLOGY AND DIRECT TREATMENT OF ADOLESCENTS *

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ADOLESCENCE is not a period complete in itself, isolated and separated from the rest of life. Actually it is one part of a whole growth process, and it can be understood only in relation to what has gone before and to what is to come after. The struggle of adolescence, its psychological aims, its failures and successes, begin to be clarified for us only as our examination of this period, with its particular differences and meaning for the individual, takes into account the manner in which it is deeply rooted in a general psychology of man and his development from babyhood through maturity. Similarly, therapy for adolescents is not a unique process, but stems from a sound psychological understanding of people and the helping situation, and from sensitive skill in the helping process as a whole.

Before a child is born, he has been a part of a physical whole, but through birth that physical whole has been broken up and he has become a separate individual. Psychologically, however, he is only at the beginning of the process of developing an ego which recognizes itself as a "self," separate and differentiated from others, as represented by parents, relatives, friends, or strangers. The child, weak and helpless as he appears to be and is, is yet not completely the creature of outer forces. There is his own inner force, which acts upon the outer world as well as being acted upon, and in individual cases it is often very strong even before the self is much differentiated.

The very young child who is forced to live as a separate entity holds to such closeness with his milieu as he can, and by identification takes in from outside—from his mother primarily, and also and increasingly from his father, brothers, sisters, schoolmates, and others—the stuff of which he builds

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his sense of himself. But the time comes when the ego is ready to dispense with so much identification and to assert itself, strengthen itself further by projection—an increased putting out. We are familiar with the idea that the way really to understand a subject is to teach it. It is around the putting out that what one knows becomes clarified, organized, and made more really one's own. So the individual must become less receptive, must assert himself, try to manage himself and others as a final step in the process of integrating what he has absorbed. Moreover, under some circumstances, the repudiation of the previous objects of identification may be an extreme one.

The most important thing about adolescence is that it brings a second chance—indeed a necessity—to find a further balance between wholeness of which one is only a part and wholeness that is all in one's self. For when the hard-won individuality is actually achieved, the fear then is that it will be lost. Such fear is not confined to adolescents, of course, but there are several factors that make it a characteristic feature of this stage of development.

It is important to remember that in his new psychological independence—which is of course not complete, but still is great compared with his childhood dependence—the adolescent is torn between feelings of strength and feelings of weakness. He has powers of which he has been unaware before and which the new ego rejoices to affirm. Yet, long used to checks from outside, at times he is afraid of these new powers, turns away from assertion of his ego, and tries to find forces outside himself to support him in the denial of his own strength. Perhaps this explains in part some of the exaggerated identifications that we find in the adolescent, in which the beliefs, the mannerisms, the very appearance of another, are taken on temporarily. On the other hand, whatever is felt as too great an enemy of the self, whether it is strengthened inner impulses or outer pressures, is fought with all the forces at the individual's command. He has to learn all over again—and this time more deeply—that it is possible to preserve one's entity and even enrich it while at the same time lending one's self to many and varied experiences in which one may act with all or a part of one's self to form a part of another and a greater whole.

Ever since G. Stanley Hall's volumes on adolescence, most writers have seen the physical, and more especially the sexual, growth and maturity of this period of life as the factor in which its psychology is rooted, yet there has by no means been agreement as to the nature of the relationship between physical puberty and psychological adolescence. Recently Anna Freud has concluded that the anxiety resulting from the *strength* of his *instincts* is the characteristic problem of the adolescent, rather than anxieties associated with any one specific drive such as the sex drive. "Young people . . . seem to fear the quantity rather than the quality of their instincts."[1] My experience coincides with this observation.

There is certainly conflict over sex in the normal adolescent, yet here is a new source of individual satisfaction and power; why does he not take it as such, enjoy it, and find in it enrichment of the ego? Anna Freud attempts to answer that question by speaking of a disposition to repudiate the sexual instincts as "a kind of deposit accumulated from acts of repression practiced by many generations and merely continued, not initiated by individuals."[2] Such an unsatisfactory explanation as this is unnecessary because the answer to the question of man's ambivalence toward sex lies in a more complete understanding of the meaning of sex to the individual.

Rank has repeatedly pointed out that sex is a collective as well as an individual force, and is so felt by humanity. If this is so, it is not strange that the adolescent feels his sexual impulses as dangerous to his newly won independence and sense of himself as a person. Rank comments on it as follows:

> "At all events we need no external sexual prohibition, no castration trauma, as our daily experience with children shows, to explain the struggle of the individual ego, the conscious will, against generic compulsion. The parents or others in authority may represent to the child powerful wills, but one can oppose them openly or secretly, one can finally overcome them, perhaps can even free one's self from them or escape them. Sexuality, however, as it awakens in the individual about the time of puberty is an incomparably stronger power than all the external authorities put together. . . . It is so strong and dominates the individual so extremely that soon he begins to defend himself against its

[1] See *The Ego and the Mechanism of Defense*, by Anna Freud. Translated from the German by Cecil Baines. (International Psycho-Analytical Library, No. 30.) London: Hogarth Press and the Institute of Psycho-Analysis, 1937. p. 168.

[2] *Ibid.*, p. 172.

> domination, just because it is a domination, something that interferes dictatorially with his own will as individual, appearing as a new, alien, and more powerful counter-will just as the ego is strengthened by puberty. The reason the individual defends himself so strongly against it is because the biological sex would force him again under the rule of a strange will, of the sexual will of the 'other,' while the ego has only just begun at this time to breathe a little freely out from under the pressure of strange authoritative wills."[1]

In our civilization the solution of the struggle between the generic and the individual in sex—and one that is possible for many people—lies in the individual love relationship, in which what is generic is accepted for what is felt as purely personal. That involves, however, lending one's self as a part of a relationship, and this is just what the adolescent fears. For that reason, one finds him trying many schemes for bringing this new force under control, so that he can have the additional richness stemming from it without paying the price which he is afraid is too high. Certainly there is an element of control in the adolescent swings between complete asceticism and instinctual excess, upon which Anna Freud comments. *He* sets up a rigid régime for himself; *he* lets *himself* go in a welter of self-indulgence. It is he who is the master—not nature. This is an assurance that the adolescent ego needs.

Many promiscuous girls use the sex act, without feeling for the "other," as a substitute for risking themselves in more real relationships. It is another attempt to control nature. One such intelligent seventeen-year-old girl showed clearly that sex for her was not living, but an evasion of living. She had no feeling for the boys and men with whom she was temporarily involved; all of her satisfaction was in her power to get them, through sex, to do what she wanted, and in her own lack of feeling response to them. Once she was talking about how people take advantage of you if you let yourself have feelings about anything. "Sometimes I think I should have been born dead. . . . By being dead I could have escaped living." It is significant that she does not wish she had never been born, but rather that she had been "born dead." It would have been better to have it over with than to lose herself a little at a time through living. One

[1] See *Truth and Realty*, by Otto Rank. Translated from the German by Jessie Taft. New York: Alfred A. Knopf, 1936. pp. 97–98.

can easily see that her use of sex as a substitute for feeling in a relationship saved her from all real taking or giving in the relationship.

It is well, then, to keep in mind that the adolescent must make an adjustment to a great inner physical change which will have many different meanings for him, but which at best will be the source of some conflict because of the contradictory generic-individual values of sex. It is also well to remember, however, that, with adolescents, a problem that on the surface appears to be a sexual one may prove to be fundamentally something quite different. Sex and sex behavior are there, ready at hand, the things that are often most upsetting to one's elders, and hence useful in one's struggle to achieve and retain one's individuality.

That there is a creative element in adolescence is implicit in all that I have said, and it is true that opportunities for the use of this creativity in the immediate life situation of the adolescent are inadequate in our society. In 1800 the mean age in this country was sixteen. The adolescent in a very real way was helping to make the world in which he lived. With the decrease in the birth rate and the increase in the span of life, the adolescent has less to do with helping to make a world and more with having to adjust to one made largely by his elders. Therefore, just at the point where he has cast off his child's adjustment to society, has reached some measure of individuality, and is faced with the task of working out a more mature relationship to society, he discovers that at present it offers few opportunities, such as marriage, job, and so on, for working out the new relationship. He is expected, for a few more years, to go on adjusting to society as he finds it—with the result that too often his creative force and his struggle turn back upon himself or become involved in a fight against society rather than in creativity.

This is a somewhat extreme statement of the situation, for which most adolescents after all do find a solution. The new ego, fearful alternately of its weakness and of its strength, but most fearful that through either it may lose itself, ordinarily finds—through taking a risk here, another there, through lending itself to experiences that prove after all enriching as well as debilitating—that the choice is not between all or none. The adolescent learns to live the inner,

and at the same time to accept the outer, not merely because it is inevitable, but also because it is, at least in part, an expression of himself and of what he wants and needs. Thus the adolescent reaches maturity and reaches it by way of his adolescent struggles and his solution of them.

Therapy is difficult to define, but the nature of therapy can be described. In a previous article on the psychology of helping, I said:

> "It seems to me that ideally therapy provides a situation in which the patient is not only permitted, but even helped to be all of himself in feeling—and in which this is possible largely because the therapist responds to the patient, in terms of the patient's feelings rather than with his own. The situation is a 'real' one for the patient in that it involves a relationship with another person, has inherent as well as external limits like time and space, and arouses very real feelings and impulses. It is unreal in that he is tied to the situation only by his own feelings and not by those of the therapist, which means that he is free to risk himself in the experience without the consequence which might follow in actual life. It is because of this, and because the therapist is there to carry the different parts of the self that the patient must from time to time project into the therapeutic situation, that with the therapist's help he gets courage to own them and to take them back again, and slowly and painfully lays the foundation for a new organization and a more constructive use of that self. . . . Thus it is not so much his feelings about . . . [others] which the adolescent brings into this experience, as it is his feelings about himself, and the therapist stands less for mother or father than he does for different, and particularly unadmitted and unaccepted parts of himself."[1]

The process whereby the therapist lends himself to the projection of his patient, and at the same time gradually helps him take them back into himself, can be thought of in terms of movement and balance. The theme is the patient's and is, therefore, different in each case, but as the adolescent moves in the hours with the therapist—now dangerously far in one direction, now in tangled confusion leading nowhere—it is the therapist who in words or action provides the balance to the too extreme movement, or himself moves to cut through the confusion and thus enable a new balance to form.

It is obvious that therapy cannot be learned as rules and regulations, things to say or do at a given time. Such things vary from case to case and from hour to hour in the same case. We can take a simple example. In a first hour when

[1] See "A Psychology in Helping in Work with Adolescents," by Dorothy Hankins. *The Journal of Social Work Process*, Vol. 1, No. 1, 1937. pp. 98–99.

a girl projects on to me her wish to be different in order that she may resist it, I repudiate all interest in whether she changes or not. In a later hour, when she has shown some signs of wanting to change and of being uncertain whether she can, and says shyly, "And I think you want me to be good," I do not refuse her temporary support, even though I am careful not to take away from her her own wish to be different. I may say, "Yes, I do want you to be good if you want to be. Do you?"

There is another point that has a bearing upon the activity of the therapist. The very nature of therapy calls for some wish on the part of the patient himself for such therapy, and yet the adolescent is often "brought" for treatment. In that factor lies both the opportunity for help with his problems and the danger that he can make no use of the experience. In general it is the nature of adolescents to see the source of their troubles as outside themselves; and where that is not so, and they are only too well aware of inner difficulty, seeking help from another person looms as just the sort of risk they most fear. In working with adolescents one must always be prepared to let an individual go, and to let him go freely, after a few appointments in which he shows no evidence of getting beyond the point of being brought. That is true regardless of the lightness or seriousness of the problem, for in the long run a person must be held in the experience by his own feeling, if any good is to come of it. Moreover, if parents or other adults are pressing to have appointments continued, it may be necessary to refuse. The skillful handling of such a situation may have therapeutic value for both adolescent and parent.

Most adolescents, even those who come alone and of their own accord, begin by saying that some one else thinks they need help. Some who are brought say that they do not know why they are here. In either case the chances are that the adolescent will in the beginning try to project upon the therapist the urge to improve or change him. If the therapist falls into the error of accepting that projection, he is lost, and worse yet, the adolescent is lost, too, so far as any help from the therapist is concerned. Yet it is just the deep feeling that most adolescents have about the danger of change and the association of that danger with coming to a therapist that

enables them to become engaged with a therapist who is genuinely willing to let them find acceptable change if they can or to stay as they are if they must.

This is not to say that, because the therapist does not take the responsibility for the coming in the first place and does not hold the adolescent against his will, he has no responsibility in the matter. There are circumstances in which one takes definite action leading to the return of a patient where one has reason to believe that such a return may be usable and helpful, and the direct handling of questions as to continuing or stopping, and the adolescent's feeling about them, is only one part of the therapist's responsibility for recognizing, regardless of content, and for responding to, whatever the adolescent is bringing to the interviews, so that from the beginning he is engaged in the new experience. Thus engaged, the adolescent is no longer merely being brought; in the most real sense, he is bringing himself.

With adolescents one needs to be particularly alert to the meaning of the verbal content that they use. Because we think of sex as important to adolescents, they can use talk about it as a safeguard against doing anything about a real problem, sexual or otherwise. Moreover, once started, many older boys and girls can talk well about many subjects. It is a part of the intellectual creativity of this stage of development, and it is so easy for the adolescent to avoid facing his own problems by good talk about the problems of the universe, if the therapist responds to the verbal content rather than to the use made of it. I do not mean that one should not talk about all sorts of subjects with adolescent patients, but rather that one needs to know, in so far as is professionally possible, what purpose the talk about sex, photography, poetry, movies, foreign affairs, is serving, and to respond accordingly.

Time and space have been mentioned among the "real" factors in the therapeutic experience. Where the adolescent is brought to treatment, there is another factor that is real both for the patient and for the therapist, and that is the adult who brings the adolescent and who has something at stake in the results. While the adolescent is coming once a week, his parent may come in to see a different worker, perhaps only a few times, perhaps every week or every other week, or at some other time interval. Parent and adolescent

will almost inevitably at times try to use the therapist and the case-worker for their own ends against each other, but this need not be fatal if the workers do not identify themselves with one against the other. Any detailed consideration of this point would take us into the whole question of case-work with the parents of adolescents, which is so important, but which we have not space to discuss here.

There is a question at times as to what use the therapist makes of what he knows about his patient through the other person. In general, it supplements the knowledge secured from the patient and may not be used directly with him. Yet this is not always the case, and I am convinced that there are circumstances under which the direct handling of such material is not only helpful, but necessary. For example, I once worked with a girl who was referred from an institution, and who accepted coming on the basis of her unhappiness over her relationship to her mother. The unhappiness was real enough, and she talked freely about that situation, but she also described herself for several weeks as getting along beautifully at the institution. Actually she was behaving very badly, as I was almost sure from the interview hours themselves, but she took her first step in doing something about her behavior and even about her unhappiness only when I told her that I knew she was causing constant trouble at the institution.

It is important not to take over the outside, to ally one's self with it, any more than with the adolescent himself. The balance of the therapist's relationship to the patient, and to both his inner and his outer conflicts, is a delicate one, but it becomes more possible to maintain if one accepts and respects the reality of the adolescent's life situation as well as the reality of his inner feelings.

For the case-worker, there is another reality—her agency and its particular function. Since in a paper so brief there is no space for an adequate consideration of case-work with adolescents, I can only call attention to this point in passing, but in the previous pages there are many implications for case-work with that age group. The reader will be able to see them for himself.

In closing, may I say that some adolescents come to treatment because they have built up so little self with which to

meet the pressures and demands of the grown-up world; some come because they have built up such a sense of themselves, so much individuality that they cannot let themselves go into relationships in the grown-up world; but whatever their symptoms, they are trying to cope in some form with the problem of who and what they are. They are struggling to become themselves, and at the same time their need for individuality is in conflict with an equally pressing human need—to lose themselves in something greater than themselves.

The severity of the conflict—and some degree of conflict there almost certainly is for every adolescent—depends in part upon external circumstances, in even greater part upon the course of his development up to adolescence. Children who have had natural, normal opportunities for psychological growth and development may bring to the problems of adolescence a healthy individuality, neither hopelessly dependent nor uncomfortably independent, which enables them to reach adulthood with comparatively little distress to themselves or to others. They face the task of adjustment to society with the ability to find in many of its aspects expressions of themselves and their own wills, and are, therefore, free to contribute to society according to their abilities.

But whatever the degree of the adolescent struggle, when the adolescent comes for therapy, the struggle is injected into the new relationship and it is this fact that enables the therapist to help him. The adolescent is afraid to live for fear that he will lose his individuality, his self. He needs to learn to partialize this fear, and he has a chance to do that in the therapeutic situation. Through the experience which the therapist helps to create, he can learn that both to assert oneself and to give in are a part of living and not necessarily destructive of the self. There is death to come at the end, but in the meantime there is a life to be lived, and the adolescent who can live it, without too great a denial of himself or of others, is beginning to leave adolescence behind and is well along the way to a mature adulthood, due to the new balance that he has achieved, and achieved through his adolescent struggles.

A STUDY OF COMMUNITY ATTITUDES TOWARD MENTAL HYGIENE

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THE following article is a brief summary of a series of interviews held during the summer of 1941 with a sampling of the leadership group of Dallas, Texas. The interviews grew out of a desire on the part of a group of physicians to determine to what extent mental hygiene enters into the civic, business, and professional activities of the community. Designed to give a representative rather than a complete picture, the study was of an informal nature. Whatever interest and significance it may have lies in the light it may throw upon the present stage of development of the study and practice of mental hygiene and upon further needs.

The interviews were conducted by a layman under the guidance of Dr. Eugene L. Aten, of the Dallas Child Guidance Clinic; Dr. Tom H. Cheavens, of the Neuropsychiatric Division of Baylor Hospital; and Dr. Robert L. Sutherland, of the Hogg Foundation.

An attempt is made here to show what the term "mental hygiene" means to the individuals interviewed and what needs were expressed.

When the question, "What is mental hygiene?" was asked directly, only about one out of three of those interviewed ventured a definition, the others either frankly confessing that they had never consciously thought of the subject or preferring to answer indirectly. The definitions that were given represent varied points of view. Although sometimes, as in the case of a sociologist, there was a very definite belief that mental hygiene has embraced too broad a field without sufficient effort to delimit itself, the more general tendency seemed to be to ignore any possible limitation. In the words of one, a teacher working primarily with adults, "Mental hygiene is a part of our everyday living and cannot be set aside to be studied as we do mathematics." Or as a proba-

tion officer stated, "Mental hygiene has to do with everything (from proper garbage collection on up) that contributes to everyday living—with those things that make it possible for us to function with a certain amount of satisfaction to ourselves and others." To others—a physician actively interested in public education and a club woman also interested in school administration, for instance—mental hygiene means primarily adjustment to life, and may be defined as "an educational process in correct habits of thought that lead to proper adjustment." Another, a school director, gave "mental security" as the objective of mental hygiene.

In several cases there seemed to be a fairly obvious relationship between the work of the individual interviewed and his definition. A prominent churchman, for instance, declaring that mental hygiene might well concern itself with family relations, stated that good mental health should be brought about to a great extent by the establishment of higher social and moral laws in the hearts of people. "Psychiatry and education, too," he said, "should be linked up with the divine and the eternal." A pediatrician, defining mental hygiene directly in terms of his own work, gave as the chief aim of mental hygiene the establishment for the child of a smooth, consistent environment based on fairness.

For a few of those interviewed mental hygiene implied treatment of mental illness, while for still others it meant simply "having clean thoughts." In several cases there seemed to be no distinction between mental hygiene and psychology or psychiatry, while in others mental hygiene was interpreted as welfare work.

In most cases it is possible to list the responses under the arbitrary and general headings "favorable" and "unfavorable," with perhaps a third heading for the "indifferent" or the "unaware." The favorable category here includes the replies of those who have, or who are consciously seeking, a positive approach to mental hygiene as it is involved in their work. The comparatively small number of persons who responded unfavorably seem to fall into two groups: those who find fault with certain practices or attitudes of mental hygienists and those who have had personal experiences of an unpleasant nature. The third category of the indifferent and

the unaware sometimes includes persons who may be doing sound work in mental hygiene, but without any conscious effort or any attempt to define their work as such.

In the group whose responses implied a positive attitude toward mental hygiene may be included leaders and officials in the Civic Federation, the Neighborhood Councils, the Volunteer Service Bureau, the Social Agencies Council, parent-teacher associations, and an evening school; representatives of the professions of the ministry, medicine, law, and teaching; and such others as a probation offcer, school administrators, directors of religious education, and a sociologist.

Among those who fall into the group who seemed to be indifferent to or unaware of the fact that they are engaged in activities that involve mental hygiene were a merchant, several personnel directors, a public-health officer, a public-welfare official, a city-government official, the director of a Federal agency, and a member of the Chamber of Commerce. This group, it should be repeated, is in many instances actively and successfully engaged in work that has mental-hygiene implications.

In the group whose responses were largely unfavorable, some felt, as was mentioned above, that the mental hygienist has failed adequately to define his field or the scope of his activities. One individual, for instance, who is prominent in women's social and civic organizations, and whose attitude toward psychiatry is indicated by the fact that she is taking her own apparently normal children to the child-guidance clinic, felt that mental hygiene has been given too broad a definition. The same reaction was given by a sociologist, who felt that the mental hygienist had overstepped the limits of his field. "Mental hygiene," he declared, "is not a social science, though it may make use of all sorts of social-science materials, nor is it education, though the mental hygienist sometimes attempts to include the whole field of education." Still another of those interviewed, a school official, citing an instance in which an unqualified person had set himself up as a psychiatrist, expressed the need for a definition of terms and a clarification of activities. This individual, incidentally, declared that he had observed more effective work by a sociologist than by psychiatrists working with the same chil-

dren. In the course of the interview, he also declared that teacher training already includes sufficient training in mental hygiene and that there is, therefore, little need for further courses for teachers.

A further objection was voiced by a civic-minded banker. Enthusiastic about youth, its welfare, and its opportunity and ability to find its aptitudes and to adjust itself to life, he has become skeptical concerning the ability of the mental hygienist to help. He observed that there is too much emphasis upon abnormal psychology even in the treatment of the normal—a tendency to "make cases"—and declared also that those who attempt to help youth too often seem to be maladjusted themselves. In this connection he noted that many are educated to be teachers, and thereby to become the guides of youth, who should be directed into industrial work.

Another of those interviewed, a business man of considerable influence in community activities, expressed an interest in mental hygiene; but, evidently as a result of having received little help in family problems that he had taken to mental hygienists and psychiatrists, he strongly objected to much that is done. He not only criticized methods of treating the mentally defective, but also attacked the work that is done among the normal. He expressed the belief that not too little, but too much has been done for people, resulting in the stunting of individual initiative and the discouragement of such qualities as fortitude and independence. He particularly criticized the retreats designed for the privileged few which are such attractive havens that the patient escapes back to them rather than face reality.

As to the needs mentioned by those interviewed, almost without exception they could be listed under the general heading, "Community Education." Though many of the needs reflected the particular occupation or profession of the individual interviewed, there were needs that reached across occupational boundaries and directly concerned the whole community. One that was repeatedly mentioned had to do with the lack of interracial understanding and sympathy, with specific attention to the inadequate provisions for helping the Negro meet his problems. A second concerned the handling of juvenile delinquents; and a third had to do with

the school-age boys and girls who, for one reason or another, are not attending school and who are receiving inadequate attention.

It seems significant that, with one possible exception, every individual interviewed who belonged to one of the professions expressed the belief that increased training in mental hygiene should be included among the educational requirements for his profession. A lawyer, for instance, declared that, with the exception of the juvenile courts, the courts of Texas almost ignore the mental-hygiene approach. He referred particularly to the need for such an approach in the domestic-relations and the criminal courts. Action, he felt, is needed both in the direction of adding courses in mental hygiene to the curriculum of the law school and in that of educating public opinion to the point of bringing intelligent pressure to bear upon the bar. Ministers interviewed, noting the many occasions in which the minister is called upon for counseling whether he is competent in such work or not, stressed the importance of adequate training in mental hygiene and human relations. Emphasis was placed upon supervised clinical experience. A leader in medical education, while granting that there is a certain amount of psychiatric training in the doctor's curriculum, was of the opinion that the curriculum, though already crowded, does not include enough such training. He stressed the importance of a positive approach to mental hygiene from childhood, and urged the importance of so training the teacher that she will be able to assume her responsibility in helping to put into effect a mental-health program. In this connection, it should be observed that the rôle of the teacher in the mental health of the community was repeatedly emphasized.

A number of cases revealed a desire for help, both in the form of institutes and conferences for the discussion of community problems and in that of counseling and guidance in personal problems. The institutes mentioned included those involving social-service work, both from the point of view of the actual worker and from that of the layman; parent education; public health; racial problems; defense emergencies; human relations; and public-school counseling. A need was expressed for increased counseling facilities both for school children and for adults. A particularly urgent request was

made by representatives of such groups as the parent-teacher associations, who expressed the need for simple, practicable rules or principles of mental health.

The following list of needs suggested by those interviewed is of interest:

1. A community-education program including
   a. Institutes for those doing social-service work, and city-wide conferences on social-service work for the laity.
   b. Institutes and clinics for parent education.
   c. The setting up and promulgation of simple rules or principles of mental health.
   d. A practical, "down-to-earth" approach to mental-health problems.
   e. The development of a better understanding of the public-health program.
   f. Institutes for the study of racial problems.
   g. The publication of bibliographical material for the use of the laity.
   h. Training for defense emergencies, including (1) the development of adaptability and of attitudes that will help the individual to face emergency conditions; and (2) training in such problems as the care of children in case of emergency.
   i. An understanding of the necessity for birth control among defectives.
2. In-service training for counselors and teachers.
3. Increased understanding of mental hygiene among teachers.
4. Acceptance by the schools of the concept that the school is a social agency.
5. Increased counseling facilities in the schools, with emphasis upon the guidance both of the abnormal and of the normal.
6. Teacher education and training in the handling of such problems as defective vision among students.
7. Increased consideration of "the middle group of children"—those who do not constitute mental "cases," but who need guidance.
8. More careful consideration of school-age children who are not attending school.
9. The establishment of a good nursery school.
10. More careful guidance for people planning to enter the teaching profession, with re-direction where it seems advisable.
11. Increased guidance facilities and psychiatric services for adults. (The need for expansion of the child-guidance clinic was expressed many times.)
12. More adequate training in human relations and mental hygiene for lawyers, doctors, ministers, and teachers.
13. Application of the principles of mental hygiene in the law courts. (It was pointed out by one of those interviewed that in Texas a mental-hygiene approach has been attempted only in the juvenile courts, nothing having been done in this connection in the criminal courts or the domestic-relations courts.)
14. Legislation to provide more adequate facilities for the treatment of mental cases and a publicity program designed to interest people in such needs.

15. More intelligent treatment of the Negro problem.
(Specific problems mentioned include the excessive homicide record among Negroes; "fixed bondsmen"; lack of responsibility among Negroes for keeping order among themselves; inadequate institutions for caring for abnormal Negro boys and girls; school curricula not planned definitely to meet actual needs; and lack of Negro consultants to work with Negroes on their problems.)
16. Greater unification of the several hundred men and women directly engaged in social-service and mental-hygiene activities.
17. An organized pressure group to encourage community progress and to achieve desired social legislation.
18. Civil-service requirements for probation staffs and other city, county, and state officers.
19. The employment of trained probation officers and parole officers to replace volunteer boards.
20. A more carefully planned program for handling juvenile offenders, including more adequate detention facilities; expansion of boarding-home programs; more adequate training of those handling offenders; the addition of special officers and a social psychiatric worker to the probation officer's staff; and the allocation of responsibility for juvenile offenders to probation officers.
21. More rigid exclusion of "poor mental risks" among draftees.
22. Clearer definitions of the training and scope of activity of the mental hygienist, the psychologist, and the psychiatrist, respectively.
23. A survey of occupational satisfactions and dissatisfactions.

A few individuals suggested that many of these needs might be met by a mental-hygiene organization. Most of these individuals, however, strenuously objected to the application of the term "mental hygiene" to a lay group. Their antagonism apparently grew out of a feeling of timidity and of aversion to associating themselves with a group that seemed to them to assume specialized training and knowledge on the part of the members.

MENTAL-HYGIENE ASPECTS OF A DISTRICT HEALTH PROGRAM *

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FEW of us can foresee the far-reaching effect that the emphasis upon mental health is going to have upon the scope and direction of our entire health program. Every one, however, must realize that in order to insure the full beneficial effect of this new emphasis, we must have, at the outset, a clear understanding of what is meant to-day by "mental health," and we must be able clearly to interpret this to our personnel and to the community.

The term "mental" is losing its usefulness because it is too limiting and because it conveys an idea of localization that is misleading. Most people are under the impression that "mental" refers to the head or to the brain. Also, the terms "mental," "mental health," "mental disease," "mental hygiene," all imply a duality—a "body and mind" concept of the individual—that is absolutely counter to the fundamental working concept of modern medicine—that is, the concept of psychobiological integration, of the individual as a wholly integrated process. We are now coming to think more in terms of interdependence and interrelationship. It is the whole person who is involved in every illness and in every state and degree of functioning.

In medicine, the pendulum is swinging away from super-specialization. Instead of reasoning from the part to the whole, the new trend is to reason from the whole to the part. Where we do specialize in medicine—or where, for example, we set up special subcommittees, as has been done in this health committee—it is important to keep in mind that this represents a focusing of attention upon different aspects of a *total process*. We are apt to lose sight of the fact, demonstrated by modern embryology, that to any and every stim-

* Presented at the Annual Meeting of the Lower West Side District Health Committee, New York City, May 21, 1941.

ulus, the individual first responds as a whole, that integrated action or reaction of the whole human being always precedes the action or reaction of his individual parts.

It follows, from what I am trying to say here, that if we give mental health its true interpretation, we must see that it is the concern not of any one committee, but of all committees.

The effective interdependent operation of our various subcommittees is possible only if we interpret health in the broadest possible sense as meaning physical, mental, and emotional health. We can maintain our integrated operation only if we realize that no one of these three aspects of human functioning—the physical, the mental, and the emotional—can be considered or dealt with separately, because they are integral and inseparable parts of the whole process that we call a human being.

Our continued success as a health committee, therefore, calls for less and less emphasis upon *independence* in our thinking and working, and more emphasis upon *interdependence,* using as a fitting model for our functioning the supreme masterpiece, the living individual. It is very important to realize that such interdependence, such integrated operation, in no way involves a loss of the unique nature and function that characterize each individual part. Parenthetically, it is the integrated action of unique individual elements that constitutes the basic principle of the democratic process, whereas the totalitarian process involves a gradual loss of individual uniqueness.

Effective interdependent action can be greatly facilitated by a common language. We must develop and circulate ideas and working principles that all can assimilate. The language of psychiatry, until comparatively recently, has only added to man's confusion about man. As psychiatry has become less interested in what goes on *inside* the individual, and more interested in what goes on *between* individuals, a more simple and comprehensive language and set of ideas have been utilized.

The following thoughts and concepts which come to us mainly from psychiatry can perhaps help to form a basis for a common language to assist us in our interdependent functioning:

1. We must extend our idea of dynamic integration to our consideration of the social body. Just as the *living* heart cannot be studied or treated except in relation to other members of the human body, so the *living* individual cannot be studied or treated except in relation to other members of the social body.

2. In our further consideration of the social body, the study of social anatomy (structure) and social physiology (functioning) must precede the study and treatment of social pathology (neuroses, psychoses, delinquency, crime, alcoholism, prostitution, and so on). Here we follow the basic policy of all medical education, according to which the study of anatomy and physiology is a necessary preliminary to the study of pathology. Furthermore, in our various approaches and studies, the social body as well as the human body must be conceived dynamically as structure *in* function, and not statically in terms of structure *and* function.

3. In considering environment and its effect upon total health, we must include the personal environment. We must remove the widespread belief that economic and physical conditions are the sole causes of all ill health, delinquency, and crime. To the physical and economic conditions of living, we must add the interpersonal conditions of living. What, for instance, is the "emotional climate" of the home, the school, the factory, the office? What are the intrafamilial or parental attitudes that are helpful or harmful to the growth of the whole child?

4. There must be recognition of the fact that all behavior is purposive, whether it is the behavior of the heart or the liver in the human body, or the behavior of the child or the adult in the social body. Vomiting represents the stomach's efforts to do something about its problem; delinquency represents the individual's efforts to do something about his problem. In this connection, we learn from surgery's history that, not so long ago, the substance that formed on open wounds was always removed by the surgeon because it had a foul smell and was "evil" looking. This æsthetically determined action and the failure to recognize the healing function of this substance, now called "laudable pus," greatly delayed healing and led to ugly and permanent scar formation. So, to-day, what may be described as "bad" or "evil" in the

behavior of an individual should not blind us to its purpose or function and lead us to reject that individual; otherwise we may bring about distorted and ugly character formation.

5. We can to great advantage make more use of the excellent working concept of Dr. James S. Plant—that the unruly child, the "bad" child, the delinquent or the "abnormal" child is the sensitive indicator of the presence of some prevailing problem. This will give us an inquiring rather than a critical attitude, and will direct our attention to the nature and intensity of each child's problem, and to the factors that determine each child's sensitivity.

From the above it follows that in a health-promotion program we must not think primarily in terms of problem hearts, or problem stomachs, or of problem children and problem families. Health-promotion emphasis must be upon the problems *of the heart,* the problems *of the* stomach, the problems *of* families, and the problems *of* children.

6. Regarding the problems of individuals, we must become aware of those that are created by the personal environment, especially the intrafamilial environment. Our materialistic culture, because of its great preoccupation with physical and economic factors, has been particularly slow in realizing that within the intrafamilial situation the individual is confronted with some of his most serious problems. What are some of these problems? Rejection, overprotection, erratic discipline, detachment, indulgence, unrealistic education, exploitation, restriction, male or female preference, favoritism, and sibling rivalry are terms used to describe parental attitudes and intrafamilial conditions that are, in varying degrees, common to all cultural areas and levels of this country.

It is important to realize that it is not these conditions in themselves that create serious problems for the growing individual, but rather their intensity and their superimposition. The time is not far way when all public-health services will be equipped and sensitized to identify these interpersonal conditions of living, just as they do physical conditions, and especially to detect where and when they are occurring to an unusual extent. Extreme problems impel the human being to resort to extremes of behavior, and the greater the intensity or the urgency of any problem, the greater the risk of some indiscriminate and socially unacceptable method of

solution. This would help to explain why you frequently find "genius" and neurosis, or "genius" and criminality, in the same individual or in the same family.

7. More thought must be given to the emotional aspects of functioning. We must make it clear not only that health makes happiness, but that happiness makes for health. Too often our thought is upon what the individual is doing or saying, and not upon how he is feeling. We must particularly bear in mind the influence of emotion and anxiety in contributing to bodily diseases, as well as its influence in prolonging convalescence and in determining nutritional disorders, delinquency, crime, alcoholism, industrial accidents, and so forth. There is, for example, the part played by anxiety in creating an excessive, compulsive, and indiscriminate striving for companionship and intimacy that often leads to perverted relationships and to reckless and increased exposure to venereal disease. Again, anxiety has a profoundly disturbing effect upon all digestive and assimilative functions, so much so that the most careful attention to the planning, preparation, and balancing of meals and diets is simply wasted time and effort as long as the prevailing emotional conditions are disregarded.

8. It follows that every branch of a health-promotion service must be prepared at least to recognize the various sources of anxiety. Unsolved interpersonal problems are a frequently overlooked source, and some of the most profound anxieties occur in those individuals who are, or who have been, confronted with the intrafamilial problems mentioned above. Therefore, it again becomes obvious that, in the effective fulfillment of our function, diagnosis and treatment of problems must always precede diagnosis and treatment of individuals.

In the last analysis, education has been and must continue to be the basic theme of health promotion. Here I feel strongly that the real immediate need is not to supply more and more facts and information and thus throw a strain upon those we are teaching, but, rather, to make every individual more aware of the significance and potentialities of his everyday relationships and attitudes, and of the powerful extent to which these influence the personal environment. It is not so much a matter of telling parents, teachers, recreation leaders, doctors, nurses, or social workers what to do to-mor-

row or next week, but rather to make them aware of what they are doing at the present time; to point out, for instance, what they may be doing inadvertently to alleviate, aggravate, or perpetuate serious problems.

We can and must make workers more aware of the significance of what they are witnessing every day. Many of those with whom we are working have a large store of what we can call "latent knowledge," the accumulation of years of experience. By activating this "latent knowledge," by making our people aware that they are already in possession of something of real value, we can bring about a great increase in self-respect and a more vital and constructive community spirit.

There is in this connection a great opportunity to bolster civilian morale. Irrespective of any world crisis, civilian morale should always be a major consideration of our health program. In our educational methods, if we approach individuals as if they have something to give rather than something to get, we shall be providing them with strengthening experiences that make for total well-being and for greatly heightened morale; in other words, we shall be promoting the health of our social body.

CHILDHOOD BEHAVIOR DISORDERS AND DELINQUENCY *

ABRAM BLAU, M.D.
Psychiatrist, Bureau of Child Guidance, Board of Education, New York City

OF ALL the cases referred by the schools to the Bureau of Child Guidance, the outstanding group is that of childhood behavior disorders and pre-delinquency. Many people are not aware of the close correlation that exists between these two conditions and adult crime as well. It is now a well-established fact that most criminals are repeaters and that crime usually has its beginnings in early youth. In fact, one goal in the development of child-guidance clinics has been to prevent crime, and the course of this development has revealed a chain of antisocial disorders from the infant to the adult. Antisocial behavior is now recognized as a biological, psychological, and sociological problem. We now know that its solution must be sought through coöperation in all these fields, with emphasis on its evolutionary development from childhood.

We can differentiate four types of antisocial behavior—infantile misbehavior, childhood behavior disorder, delinquency, and crime, corresponding, respectively, to the natural age periods of the pre-school period, the school period, adolescence, and maturity. All have the common feature of a failure to meet the prescribed behavior generally required for social living at the age period in question. They differ only in variations of complexity, corresponding to the age involved and the relative degree of experience, sophistication, and responsibility.

At the outset, we find that there is nothing inherently bad in antisocial behavior. It is only behavior that is wrong at a particular time. One and the same act may be condemned in one set of circumstances and approved in others. As an extreme example, let us take the killing of a human being.

* Presented at the Tenth Anniversary Conference of the Bureau of Child Guidance, Board of Education, New York City, October 18, 1941.

Murder is unanimously claimed a crime; but killing in war is praised; in self-defense, it is condoned; and when committed during the heat of understandable emotion, it is sometimes forgiven. The act must always be weighed with its attendant circumstances. Therein lies the great psychological problem of determining culpability in the courts of law. Responsibility changes with age, and even the law is not fixed. Not so long ago, truancy was regarded merely as undesirable, but nowadays, with our compulsory-education laws, it is an act of delinquency.

But one positive feature is outstanding in all antisocial behavior—it is aggressively self-indulgent and rebellious. To illustrate, the following cases may be cited:

> Robert, a six-year-old, with an I.Q. of 141, was referred because he was restless, annoying, uncoöperative, careless, and untidy. He sucked his fingers, and pinched and slapped other children. His mother confirmed these complaints and added that he was a fussy eater and a bed-wetter.
>
> Howard, nine years old and of average intelligence, was described as quarrelsome, bossy, obscene, overactive, insolent, lazy.
>
> Joseph, eleven years, also of normal intelligence, was defiant, destructive, argumentative, disturbing, stubborn, untrustworthy. He played truant from school, bit his nails, and stole small articles.
>
> Constance, a bright, overgrown, eleven-year-old girl, was disobedient, ill-tempered, untidy, unfriendly, untruthful, sexually precocious, and conceited, and habitually sucked her tongue.
>
> Oliver, aged fourteen and of superior intelligence, was unstable, noisy, restless, boastful, and disrespectful to teachers, and had frequent temper tantrums.
>
> Thomas, fifteen years old, was talkative, insolent, and rude, and rebelled at discipline. He would desert his home for days, played truant from school, was irritable with other children, and used abusive language.

The cases become repetitious in the obvious recurrence of a direct, free, impulsive expression of personal desires contrary to the standards set by the world in which these children live. Their behavior reminds one of the little child who wants what he wants at once—with no sense of restraint.

In fact, infantile behavior may be taken as the prototype of criminality. Here we see the naked original desires, the inborn biological elements, that form the basis of all later human activity, whether good or bad, social or antisocial, moral or immoral. It may be said that the human being

enters the world as a delinquent—that is, socially unadjusted. The infant is wild, uncivilized, untrained, and undomesticated. In the first years he is dominated mostly by those instinctual urges that impulsively seek satisfaction and that are unbridled by any sense of the rights or needs of others.

This state of undisciplined instinct gratification cannot last long, however. Partly through his own contacts with impersonal dangerous situations such as fire, height, climate, and so on, and partly through the teachings of his guardians, the child soon becomes aware that some control of his desires must be brought about in order that he may adapt to life. Of course, the solution of this universal problem can only be a compromise. A certain measure of emotional gratification is biologically essential to every one. This need must be met in one way or another, whether through normal, neurotic, perverse, or delinquent channels. The normal child learns how to curb his primitive impulses, to postpone their satisfaction, and to modify them along socially acceptable lines. The socially unadjusted child is a child who is failing in this development.

Education for social living is thus a two-sided problem. The individual must learn, on the one hand, how to obtain proper gratification of hereditary instinctual urges, and on the other, how to control them adequately. But what, we may ask, motivates the child to learn these adjustments? For our reply we must turn to the age-old educational principles of pleasure and pain, of reward and punishment. Well-chosen or approved ways of satisfaction are encouraged, and reprehensible patterns are censored. This process of learning is obviously so like Darwin's law of natural selection and so well-known that we need spend little time on it.

One aspect of learning gained during personality growth deserves special attention, however, because it is so closely related to the problem of socialization. This is the acquisition of a sense of right and wrong, a private moral and ethical code. The pre-school child has little understanding of how and why to supervise himself. He curbs naughtiness mainly because he fears the loss of the approval of grown-ups. In most children, however, at about the age of five or six years, we begin to find that they can be trusted with some management of their own affairs. Incidentally, it is significant that

pedagogues have empirically chosen this age for the beginning of formal education. The child now shows some self-critical concern about his behavior even when alone or when his misdeeds would not be discovered. The elements of a conscience and of ambition become apparent, and discipline and drive become in part self-imposed undertakings. By the process of repeated parental encouragement and direction, the parental point of view is gradually, yet so thoroughly, taken over that it becomes incorporated into the newly forming personality as an integral part of the child himself.

Later, after the child has gone out from the family circle, he is similarly influenced by his teachers and other authoritative and respected persons. This inner capacity for discipline remains for the rest of his life as the great ally of the outer authority in the moral, ethical, and social guidance of his behavior.

There is no doubt to-day that the basic groundwork for personality growth is laid down in the early pre-school years while the child is under parental influences. From time immemorial, pedagogues have maintained that character is made at home. Modern psychological research only substantiates and elaborates the truth of this idea. The foundations and essential framework of all the later character traits are established during the plastic period of early childhood through the precepts and the example of mother and father. The most significant education begins at home; the school only supplements from then on. It is in large part the identifications, conscious and unconscious, formed in those early years that determine the specific individual features of adult character. These experiences decide the degrees of moral stringency, self-sacrifice, idealism, and repression that are the basis of the relationships of later life. In one person the inner authority is excessive, and he may become either a rigid, inflexible type, an impractical idealist, or a psychoneurotic. At the other extreme, this inner authority may be inadequate, and the person will defy social customs with no sense of guilt.

Just how the characters of the criminal, of the delinquent, and of the child who manifests a behavior disorder are related to the love and discipline of the family circle is disclosed by comprehensive child-guidance studies. Because his need for

protection, love, and the good opinion of his guardians is greater than his desire to satisfy his instinctual tensions, the child becomes willing to make social concessions. In every one of the cases I have cited, and in many more that have been studied, the outstanding factor in the child's life was the lack of parental affection. Either the parents actually did not love the child, or because of the death or the desertion of his parents, he had never found love or understanding in his home. There was not only a temporary deprivation of some desired gratification, but a continued lack of many of the basic needs of early life. And the more severe the antisocial behavior, the more complete and long-standing the emotional deficiencies are found to be.

This is the great injustice hidden within most delinquent histories. It is far more significant than any other environmental privations, and it accounts for the occurrence of antisocial behavior among both rich and poor. The parents frequently blame the child for their rejecting attitude. They do not realize that the child's misbehavior is the effect rather than the cause of their failure to give him adequate attention.

In the light of all these facts, one final note of caution must be stressed for those who work with maladjusted children. Since so much of the child's behavior is motivated by a multitude of remote forces, instinctual and learned, conscious and forgotten, many of which he has never even recognized, can he then be held responsible for his misdeeds? The answer must be "no" and "yes." We cannot agree with the traditional concepts of "free will" because the child is as a rule quite ignorant of the real sources of his misconduct. To a large extent he is impotent in its control and is in great part merely the expression of his biological, cultural, and educational background. Really to know why he is misbehaving, we must thoroughly examine the child and his setting and evaluate them objectively. Yet, despite these considerations, we must demand a degree of responsibility from the child because it is our only means of influencing him. Although this requirement does not have complete scientific validity, it has a practical and tactical justification. As in the case of the principal who is said to be fully liable for his school, but who cannot be held really accountable for every neglect or mistake of each teacher, the rôle of responsibility is necessary

and reasonable on grounds of efficiency. Thus, only for practical purposes, we require that the individual must have the duty of responsibility for his behavior, even though we must always bear in mind his actual inner limitations.

To recapitulate, the child misbehaves because he is unhappy, and he has discovered this means of maintaining his emotional balance. Abnormal though it is, it becomes his way of obtaining satisfaction and of asserting himself. The painful price of punishment seems to him worth the gain. At least he gets some attention and is retaliating at a seemingly unjust world. The outside world has failed for him. But despite the apparent arrogance and lack of guilt, within himself he actually feels weak, fearful, deserted, anxious—all these feelings being magnified tenfold by his immature and fantastic imagination. Misbehavior in a child is thus a plea for help and a signal of distress. And relief must be given as soon as possible, before the pattern becomes habitual and fixed, and the child progresses from childhood behavior disorder to adolescent delinquency, to adult crime.

The aim of child guidance is to discover the true causal deficiencies in each situation and to introduce measures for their correction. The causes are usually numerous and may be medical, social, emotional, intellectual, educational, or economic. Moreover, since antisocial behavior is a relative condition, we must not only weigh the nature of the noxious influences within and without the child; we must also consider their extent at the special time and place, and in connection with the potentialities and make-up of the particular individual as well. Often the parents can readjust to meet the child's needs, but sometimes parental surrogates—teacher, social worker, doctor, psychiatrist—must be called upon to compensate for the failures at home.

In the final analysis, we must grant that antisocial behavior is an extremely complex problem, and its ultimate solution, if this is ever attained, will require the combined efforts of biologist, sociologist, pedagogue, jurist, and psychiatrist. Cost cannot enter the question because the community always remains liable for delinquency and crime, either at its inception or at its end stages. And regardless of how it is reckoned, prevention is always more economical than cure.

TWENTY-FIVE YEARS OF CHILD GUIDANCE *

INTRODUCTION

GEORGE S. STEVENSON, M.D.
Medical Director, The National Committee for Mental Hygiene

I AM here to bring you the greetings of The National Committee for Mental Hygiene. That is an easy and a pleasant thing to do, and while I cannot speak for the whole mental-hygiene field, I know that I can report a general and deep appreciation of 38 Beacon Street as the Mecca of child guidance and of Dr. Healy and Dr. Bronner as the major prophets.

A profound student of the processes of scientific progress has pointed out that as a rule advances have been made by the young, the unorthodox, the geniuses who could cast certain tradition aside and approach a problem "as if"—as if some of the assumptions upon which our whole education had rested were false, as if the chemical elements were not elemental, as if some geometrical self-evident truths were not true, as if bad children were not bad, as if badness grew out of life experience instead of being an inherent evil.

This same student has also shown how much the readiness of the times contributes to the flowering of genius—how events have conspired to prepare the way for his step forward, and have also supplied almost-ready demi-geniuses and immatured geniuses upon whom the "as if" step makes a deep impression. And so we find many who have shared in the councils of this child-guidance Mecca, or who have read its writings or heard its talk. We find that they have carried the "as if" to the court, as if badness were not inherent; to the social agency, as if indolence were not inborn; to public health, as if living were more than merely escaping death; to education, as if backwardness were not merely stupidity; to the ministry, as if services were not merely devotion; to general medicine, as if the sick of body were also sick of soul.

All these have turned an inquiring eye on the un-sick as if they were sick, and have not only come to a more encouraging

* Addresses delivered at a dinner in celebration of the twenty-fifth anniversary of the founding of the Judge Baker Guidance Center, Boston, April 9, 1942.

perspective on their own fields, but have found so much in common that they have bridged their differences. They have grown big enough to rise above vested interest. It is no accident that one can take any of these advances and trace the genealogy of its minor prophets right back to this work of Dr. Healy and Dr. Bronner and the Judge Baker Center.

In view of this great contribution of the Judge Baker Guidance Center, The National Committee for Mental Hygiene is happy to have had the opportunity since 1920, under a grant from the Commonwealth Fund, to promulgate the point of view and method of operation initiated by Dr. Healy and Dr. Bronner. In this year of 1942, they may look with some pride upon the development of the movement in the United States, where practically all of our large cities have planned their child-guidance services along the lines laid down here; where at least half of the medium-sized cities are equipped with such services; and where the smaller cities are rapidly developing in this direction. State by state, attention is being given more and more to the state's responsibility for its children. And the establishment in England of a child-guidance service has afforded a mainstay for children in this war time that has done much to maintain the morale of the country.

A national organization of persons interested in child guidance has grown rapidly, and at its meeting last year in New York attracted some 1,700 persons.

We of the National Committee want you to know how extensively children have profited by the work of Dr. Healy and Dr. Bronner and how much we appreciate what they have done.

THE SOCIAL SIGNIFICANCE OF THE GUIDANCE MOVEMENT

JAMES S. PLANT, M.D.
Director, Essex County Juvenile Clinic, Newark, New Jersey

EACH of us this evening is acutely aware of the extent to which the celebration of a twenty-fifth anniversary stretches beyond this room, this city, this state. The development of the guidance movement could not have been so wide

or so fast if it were not in closest tune with certain emerging concepts in the whole field of social work. It is about these that I would like to speak for a while, because the Judge Baker Guidance Center is so outstandingly, for all of us, their symbol. To a large extent they center about (1) changing attitudes toward the misfit—the problem child, and (2) the entrance of the physician and his philosophy into the field of behavior. With every sincere recognition of the pioneer work of Dr. Healy and Dr. Bronner, it yet remains that their labors would not have borne this fruit if it had not been that—in the true fashion of leaders—they had caught and implemented the spirit of their times.

Thirty years ago—and for many years after that—we were operating on the assumption that the earlier we could get hold of the child, the simpler the problem would be. We already knew full well that this was not true in the physical field. We knew that as one went to earlier and earlier phases of typhoid fever, one went to the reservoir and to the dairy—that earlier watchfulness for tuberculosis was in food and housing projects. So in the field of conduct the problem in the earlier years is not *simpler*—it is *in another place.* One's courage or one's meanness, bright-eyed faith, hope, or dishonesty—these exist in one's childhood, but then they exist in one's parents, one's school, one's home.

So we have been led out, through the child, to a necessary attack upon problems of school and industry, of housing and niggardly space for play. We no longer can sell our wares on the basis that childhood is simple and easy, but rather that it leads us to those social pressures that warp and twist. Somewhat slowly, we must continue to follow the brilliant lead of the public-health group. Otherwise we are but glorified street sweepers, forever gathering up the débris of life.

In other matters our path is not so clear. For the broken bone or the aching body, we are experts—we have data and experience that others do not have. In the matter of living, however, every individual is an expert—that is all that he has ever done. This represents a problem of transcending importance to the physician, for it forces upon him a "hand-in-hand" relationship with his patient—a relationship that neither he nor the patient relishes. The "leader-follower"

relationship, which for centuries has been so important, in this field has to be changed. When the child would know how to stop running away or playing truant or wetting the bed—oh, we can tell him that. But when, as he always does, he turns to us with the query where he can find the happiness, the recognition, the achievement he sought in these ventures, we can only say, "I wish I knew. I wonder about that, too." Here is an outstanding and ever-pressing challenge to the medical profession. It is one that we will not answer merely with more data or more courses in medical school. As the question spreads to other specialties, certainly we will increase our interest in the selection of persons for medicine and perhaps decrease our interest in the training of persons for medicine.

There is another entirely new concept that this work challenges us to accept. The physician has looked upon frustration as one of his best allies. Those checks and balances which the body has set up mean that much that we ordinarily term illness is merely the salutary sign that, for our own preservation, we must stop. Pain immobilizes parts of the body for healing; depression and fatigue often tell us that it is best that we stop certain activities. But is this true in the field of social behavior? I am not impugning the value of frustration and taboo if I point out that these are for the benefit of the group rather than of the individual. Even though they may indirectly be of great benefit to the individual, the fact remains that the physician—and others—must build an entirely new conception of the value of frustration to the individual.

For a good many dreary years we have had studies and researches and volumes as to what is the matter with the delinquent. Now we begin to see him in a new light—to see him as the *sensitive* individual—the one who measures best the pressures that assail all children. The truant has led us to question the methods of teaching reading and arithmetic to *all* children. The delinquent has taught us that *all* children need a place to play. Many a runaway has taught us that we overly schedule the lives of *all* of our children. Truly the stone that the builders rejected can be made the head stone

of the corner of a better world for all children. It is high time that we ask what is *right* about the delinquent—what this sensitive indicator is trying to tell us of the needs of all. Those millions who died of typhoid fever were not the weak —they were the sensitive, telling us that all persons need good water and milk. The millions of tuberculous have for centuries cried out the needs of *all* for better housing. The problem child, the delinquent, like the sensitive antennæ of the insect, tell us of those dangers in our environment which would spell disaster to us all. Will we heed these messages—or continue our weary search for what is wrong or weak in these who can so surely aid us?

There is one other place at which we must watch our loyalties with care. When, at the beginning of the century, the physician came into this field of behavior, he brought with him the notion of not finding fault with symptoms—of not being interested in "blame." We don't *blame* people for having a fever or some pain—and now we don't *blame* persons for running away or sassing the teacher or biting their finger nails. Nor do we excuse—we try to *understand.* But the Old Adam in us dies hard. To a very great extent we have simply moved the blame a bit further away. Much of our literature which so beautifully understands the child thunders its moralistic dicta at parents, school-teachers, others. We have started on a high road of venture—let us keep our faces toward its goal. If we are to *understand,* let us try to do so with all we touch and hear of. It is a sorry sight that we celebrate so vociferously a victory only half won.

Down through the ages two philosophies have struggled for supremacy. Some have always believed that progress and growth lie in opportunity, in some sort of manipulation of the environment. Others have had their faith in the slow, toilsome growth of each individual. Scarce a century has passed that there has not flared into searing blaze the struggle between these two—in state or church, in school or theory of sociology or economics. I am not trying to define democracy when I say that it is that form of governance which is the expression of those who have their faith in the development of the individual. Nor am I fully describing the child-guid-

ance movement in pointing out that, in slow and painstaking fashion, it would make a better world through making better individuals.

Posterity will look back upon these tragic years to see the same licking flames. National boundaries and trumped-up racial cleavages blur the issue; international racketeers throw dust in our eyes; but, really, once more these present years ask the old question, "Where is the Kingdom of God?" Is it in curriculum, or technique, in one or another form of planned economy, in ever-so-skillful manipulation of the environment? Or does it lie within the individual?

Armies and armaments, yes. But if we put our faith in these we lose the war. The battle rages in each of us—and it is precisely there that it will be won or lost. We hail the child-guidance movement for these several things that I have sketched, but chiefly because it bases its hope and its faith upon the development in each individual of the strength and stability that will enable him to win that war.

GUIDANCE AND PHILOSOPHIES OF LIFE

G. HOWLAND SHAW
Assistant Secretary of State; President, American Prison Association

FOR twelve years I have had on my conscience an obligation that I owe to two of the persons who have been most closely identified with the Judge Baker Guidance Center; and as the years have gone by and my responsibilities with respect to the lives of other people of various ages and conditions have grown, I have become constantly more aware of the reality and the extent of that obligation. This address to-night as part of the celebration of the twenty-fifth anniversary of the foundation of the Judge Baker Guidance Center gives me the opportunity to acknowledge and to describe this obligation and, in doing so, at least in some measure to discharge it.

Twelve years ago this month I spent a morning with Judge Cabot in the Boston Juvenile Court. A tousled-haired, somewhat disheveled twelve-year-old boy appeared before the court. A conventional story of truancy, incorrigibility, and

pushcart and other petty stealing was unfolded. At the outset I saw merely an unattractive small boy, and I heard no more than a rather sordid and, it seemed to me, not very interesting story. The proceedings lasted, as I now recall them, about half an hour.

I cannot speak concerning the eventual effect of those proceedings upon that boy. I have never seen him since and I do not even recall his name. But at least I can testify to the effect of that half hour in Judge Cabot's court upon the visitor who happened to be present upon that particular morning. I am not clear whether it was what Judge Cabot said to the boy, or whether it was his manner or the tone of his voice, but this I do know: At some stage of the proceedings my attitude toward the boy underwent a radical change; I found myself feeling that he was the only boy in the world and that his troubles and his future were more real, more important than anything I could at the moment think of. I had a vivid realization of that boy's essential uniqueness, of his incalculable value, and therefore of the justification, and more than justification, of the effort Judge Cabot was making in his behalf.

Probably Dr. Healy has forgotten the occasion when a rather naïve member of the Foreign Service came to his Court Street office and told him that he was going out to Turkey, that part of his duties would be to try to give some helpful advice to the Turkish Government about ways and means of dealing with juvenile delinquency, and would Dr. Healy please say just exactly what the Turkish Government ought to do?

Now to those of you who know Dr. Healy, I need not say that he did nothing of the sort. Instead, he said very simply and very clearly that he did not think our work with juvenile delinquents in this country was sufficiently successful to warrant our undertaking to advise foreign governments as to what they should or should not do in this field, but he went a great deal further than that. He described with utmost frankness the results of a then recent survey of his own work and the reorientation of that work which the survey indicated.

I had heard many people speak of Dr. Healy and of the Judge Baker Foundation; I had carefully studied some of his books and I knew his reputation and the reputation of the

foundation. I had expected from him a pronouncement—precise, clarifying, and dogmatic—and his words of dissatisfaction with his work, of uncertainty, and of awareness of the necessity of unremitting search, of a testing and a retesting of techniques and procedures came to me as a distinct shock.

Much has happened to me during the twelve years that have followed my first meeting with Dr. Healy. I have learned on my own account and through bitter experience something of the dissatisfaction with one's self and with one's words and actions that inevitably accompany any effort to deal with the problems of other people, whether young or old; I have learned something, too, of the constant reappraisal of methods in the light of experience and the painful reorientations that must characterize the intellectual life of those of us who find ourselves in a position to exert some effect upon the lives of others. During my education in these fields—and I earnestly hope that education is still going on—I have never forgotten my first interview with Dr. Healy. I should like to take this opportunity to express publicly to him and to Dr. Bronner my very real and very sincere gratitude. I owe to both of them more than it is easy for me to express in words.

On an occasion such as this, the mention of personal experiences is permissible only if those experiences have a significance and implications wider and more far-reaching than their effect upon the life of any one individual. I have mentioned these experiences of mine with Judge Cabot and Dr. Healy, not only because of what they have meant to me personally, but also because they represent what seem to me to be two of the essential conditions that have in large measure determined such success as the guidance movement has achieved up to the present time; and also because, upon analysis, they will, I am convinced, be found to contain by clearest implication the germ of what the guidance movement must become in the future if its great promise is to be fully realized.

In the first place, any sort of guidance must be predicated upon a real and a pervasive conviction of the value of the individual who is seeking guidance. Not for a moment can we think of ourselves as confronted with any mere *case* of this or that mental, emotional, or moral ailment; it is no *case*

history the pages of which we have been turning over; we have not been assembling *material* to shape our judgment and our actions. We are confronted with the life of a human being; we have been reading of the experiences that have held significance for that life; and we have drawn from other histories of life experiences hope, warning, guidance—yes, and inspiration—to help us in discharging our heavy responsibilities.

And, given the mystery of the human personality and the gaps in our knowledge concerning it, scarcely less essential for the work of guidance is a dissatisfaction with existing procedures, a zest for beginning all over again in view of the greatness of the prize to be won and the sensitiveness to *all* of the needs of the human personality which that dissatisfaction and that zest cannot fail to produce in any really thoughtful person. Certainly these are the qualities of mind and of heart that have always distinguished the outstanding student of human behavior from his more dogmatic, more perfunctory, and less inspired brother.

If you have followed me so far in what I have said concerning the value of the individual and the constructive dissatisfaction that is constantly seeking a broader and a truer conception of the needs of that individual and of ways to meet those needs, you will be prepared for the principal thought that I hope to leave with you this evening. Just as medicine, after years of at least indifference, has finally accepted psychiatry, even in its more elusive and less easily described aspect of guidance, so must psychiatry consciously recognize the rôle of values, the rôle of philosophy and even of religion. Let me give you, chosen very much at random, three examples of the kind of problem of which, it seems to me, psychiatry, in its rôle of guidance, must be able to take cognizance and of which it cannot effectively take cognizance without the development I have in mind.

Some of you perhaps have chanced to read the French philosopher Gratry's *Reminiscences of Youth,* and you recall the striking passage that I am about to summarize. He is seventeen and a half years old. He is alone in his room and it is late at night after what we should call a school prize day; he is honor boy of the school and prize after prize has been

awarded to him during the exercises which have taken place that afternoon. He thinks of his future: perhaps next year he will be first among the graduates of all the lycées of Paris; perhaps later on he will win the first prize in philosophy; and then will come the law school with more honors; and after that an outstanding career at the bar and in politics; still later possibly the authorship of notable books and election to the French Academy. His imagination, with utmost vividness, pictures one success after another.

And then, all of a sudden, a cloud begins to darken the world of intense brightness that he has conjured up: at such and such a period of time, he cannot help but realize, his father and mother will no longer be living; perhaps he will survive his wife and some at least of his children; and finally even the brilliant career about which he has been thinking will come to a close. And then, what? Suddenly the problem of values forces itself upon him, and he feels the reality of that problem with the same intensity, the same vividness with which he had previously pictured his future. What does it all mean? he asks himself.

Some years ago I had occasion to see a good deal of a youngster of eighteen. We talked of all sorts of subjects—philosophy, politics, economics, religion—but we devoted most of our time to trying to figure out what this youngster planned to do with his life, and why. That proved to be a very complicated subject, and we discussed it at great length, until one fine day, in the middle of one of these discussions, he fired at me the query: "Just what do you mean by success in life?"

My answer was not convincing. In fact, it was so unconvincing that we decided that in collaboration with him I should write an essay on "Success," and my spare time during the next two months was devoted to struggling with that essay. Never has anything that I have written received rougher treatment. The worst theme I ever wrote in freshman English at Harvard was never rewritten as often as that essay, but we finally produced something that was tolerably satisfactory to both of us.

More recently I have been concerned with the problems of another eighteen-year-older. This particular boy became

thoroughly convinced that there was no value at all in living, and he made a clumsy attempt at suicide. The psychiatrists who thereupon took him in hand, after a six weeks' period of intensive study, returned the well-worn, but not particularly helpful diagnosis of "psychopathic, but not psychotic," and the boy was promptly turned loose to face the world.

Those of us who have been closely concerned with him since that time have been struggling in every possible way to convince him that there is a great deal of value in living. We have not talked to him very much about himself, but we have tried first to convince him that we are genuinely and whole-heartedly interested in him for what he is, with his good qualities and his less good qualities, and then we have talked to him quite a good deal about ourselves, and our own ups and downs and blunders, and just why, in spite of those ups and downs and blunders, we still believe life is enormously worth living.

Please do not misunderstand me. I am not for a moment contending that mental or emotional conflicts, endocrine disorders, reading disabilities, or any other of the many things we have learned about in recent years do not have an important and sometimes a decisive effect upon human behavior. I am casting no reflections whatsoever upon the important scientific achievements of modern psychiatry. I am simply insisting that the moment psychiatry enters the field of guidance, its purely scientific achievements are not sufficient and never can be sufficient, and, whether knowingly or unknowingly, it enters a quite different field—the field of values, the field that makes it possible for us to furnish an answer to such questions as "What is the meaning of life?"; "What is success?"; or "Why is life worth living?"

I will go further than that and predict that the development of guidance in the next ten years will in large measure consist of a clearer and a more conscious recognition of the essential importance of those very values which in the past have either been discarded as false or at least dismissed as unimportant.

I make that prediction with confidence because such a development is being forced upon us by the very nature of the world in which we are now living and by the impact of that world upon the lives of all of us. Psychiatrists refer to

the adjustment or maladjustment of the individual as the criterion of their success or failure, but to what are we going to adjust the individual who comes to us for guidance nowadays? Certainly not to the world of genial and unreflecting optimism which we of the older generations have known; nor to the stable world in which careers could be foreseen, planned, and in a measure carried into execution; nor even to a comfortable world in which material well-being was a matter of primary consideration. To-day we should hope, but we certainly cannot be optimistic; instability and uncertainty are everywhere in evidence and the standard of material living of all of us will presumably be lowered. The criterion of adjustment of the individual is still valid; but the world to which the adjustment is to be made is a world greatly different from that in which the guidance movement was born and has developed.

To-day those of us who are concerned with guidance must assist the individual in fashioning an intellectually coherent and a satisfying life out of heavier responsibilities, and responsibilities incurred at a far earlier age, than our flight from maturity has heretofore considered admissible, out of uncertainty, discomfort, suffering, and sacrifice. That is no mean task, given the more immediate past from which we must free ourselves, and we shall not accomplish it by recourse to any one of the limited philosophies of life that seemed to many of us valid only a few years ago. Rather, must we carry that sensitive regard for the individual which Judge Cabot brought to the work of his court and that constructive dissatisfaction of Dr. Healy to their logical conclusion and recognize that the ultimate goal of guidance is the fostering of values in the individual and the stimulating of that individual to the fullest possible participation in living in accordance with those values.

MENTAL-HYGIENE PROBLEMS IN AN URBAN DISTRICT *

FOURTH PAPER

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THIS paper is the fourth in a series of reports on the findings of a survey of mental-hygiene problems in the Eastern Health District of Baltimore. A full description of the district, of the methods of case finding, of the statistical procedure employed in the study, and of the system of classification used, will be found in the first paper [1] of the series. The present paper discusses the cases found among children aged seven to sixteen years, inclusive.

This decade of life corresponds roughly to the period of general school attendance, although most of the children in the first grade are not included and some of the older adolescents have left school and are either employed or seeking work. For convenience, however, the group will often be referred to as the children of school age.

It should be explained why the age period seven through sixteen was chosen rather than that of six through fifteen, which would have followed the actual age distribution of school children even more closely. The public-school system is one of the major sources of cases in our survey. Very few children, however, are reported from the first grade; apparently difficulties that exist or that develop at this period require some time to come to attention and to be recorded.

* This study was made with the support of the International Health Division of the Rockefeller Foundation.

[1] See MENTAL HYGIENE, Vol. 25, pp. 624–36, October, 1941.

Inclusion of the six-year-olds would, therefore, have given a fallaciously low impression of the number of disorders in the age group as a whole. On the other hand, it was felt desirable to take the seventeenth birthday rather than the sixteenth as our upper age limit because seventeen seems, as a rule, to be the age after which offenders are no longer tried in the juvenile court. Older delinquents are brought before the magistrate at the police court, and the dockets of this institution do not usually afford much psychiatric, psychological, or sociological information.

The total number of persons in the age group seven through sixteen enumerated in the Eastern Health District by the National Health Survey in 1936 was 10,636—19.3 per cent of the population of all ages. Of this number 5,357, or 50.4 per cent, were boys and 5,279, or 49.6 per cent, girls. The whites numbered 8,005, or 75.3 per cent, the Negroes 2,631, or 24.7 per cent, of all these children. The economic status of the group is indicated by the fact that about 14 per cent of the white and about 45 per cent of the Negro children were members of households in which at least one member had received relief at some time during the year preceding the canvass.

The 43 sources covered by our survey yielded a total of 1,242 children in the age group seven through sixteen who presented some form of mental-hygiene problem. What this term includes will become evident in later paragraphs. These 1,242 children appeared in the records of our sources 1,862 times, or 1.50 times per case. For all other cases in the survey—mostly adults, with a very few small children—the number of contacts per case was 1.26. This difference is an indication of the more complete recording and better recognition of problems during school age.

A summary of the sources surveyed and of the number of cases found in each is presented in Table 1. We see from this that more than half of all contacts were those with the public-school system. Next to the public schools, the most important sources were the social agencies, the National Health Survey, and the juvenile court.

Of all cases, 79.5 per cent were identified with census individuals and 4.5 per cent with census households; 15.9 were non-census. Compared with the identification data for

TABLE 1.—CONTACTS WITH ACTIVE CASES AGED SEVEN THROUGH SIXTEEN YEARS, BY SOURCES

Source		*Number of contacts*
Hospitals for mental disease		3
Training schools for the feebleminded + waiting lists		52
Psychiatric clinics		126
Social agencies		182
Public-school system:		
Psycho-educational clinic	194	
Special classes	714	
Attendance department	54	
		962
The juvenile court		151
Training schools for delinquents		65
Police and criminal courts		144
National Health Survey		174
Other sources		3
All sources		1,862

the whole groups, as given in the first paper of this series, there were proportionately but half as many children identifiable only as members of census households. Similarly, the number of non-census cases was smaller by a third than was the case with the total group. These differences in identification are apparently due to the fact that the great majority of children in the population are members of the immediate families of the heads of the households they belong to and have the same names. Adult members of the household may be statistically "lost" if the family moves during the course of a long hospitalization, but this is rarely the case with children.

The system of classification of the case material covered in the present paper follows the principles outlined in the first paper of this series. Some rearrangement of groups, however, was felt desirable in presenting the data for this age group. Table 2 shows the distribution of the 1,242 children by leading diagnosis. This table shows also the total number of cases in each diagnostic group. It will be remembered that the "hierarchy" of conditions was arbitrarily established and does not reflect the importance or the severity of the problems in each case.

The number of psychotics is small enough to permit of a description of each individual. Three of these children were

TABLE 2.—DISTRIBUTION BY DIAGNOSIS OF ACTIVE CASES AGED SEVEN THROUGH SIXTEEN YEARS

Diagnosis	*Total cases with diagnosis*	*Cases with diagnosis as leading classification*
Psychosis	4	4
Neurotic traits	140	140
Conduct problems	371	311
Minor personality traits	62	56
Epilepsy	40	18
Mental deficiency	403	282
School-progress problems without mental deficiency	592	431
		1,242

hospital cases—one a white boy, aged fifteen at first admission, who was diagnosed as psychosis with epileptic deterioration; one a white girl, aged sixteen, with dementia praecox; one a Negro girl, aged twelve, who was admitted to hospital with the diagnosis of psychosis with mental deficiency. The fourth case was a white boy, fifteen years old, with paranoid traits.

The next group consisted chiefly of individuals considered as cases of "behavior disorder in children—neurotic traits." This term was borrowed from the *Statistical Manual,*[1] but it covers the "habit disturbances" of the *Manual* as well as the so-called "neurotic traits." The group embraced a great variety of problems, including items such as habit spasm, nail-biting, enuresis, and stuttering. We are aware of the shortcomings of this classification, but we wished to conform to official usage so far as possible. As we pointed out in the first article of this series, different yardsticks had to be used for juveniles and for adults in the study of neurotic behavior. In a child a single symptom or behavior trait was sufficient for classification of the case as a behavior disorder, whereas in an adult an estimate of the whole personality was attempted.

In addition, the group included a few adolescents originally classified as psychoneurotics (five cases) or a "personality disorder in adults—neurotic traits" (three cases), and some

[1] *Statistical Manual for the Use of Hospitals for Mental Disease,* prepared by the Committee on Statistics of the American Psychiatric Association in collaboration with the Department of Statistics of The National Committee for Mental Hygiene. Tenth Edition. Utica, New York: State Hospitals Press, 1942.

"nervous in census" (eight cases) who happened to fall into the age range seven through sixteen. Further problems of interpretation will be discussed after the numerical findings have been presented.

The group of conduct problems is the group classed in the *Statistical Manual* as "conduct disturbances." Definition is clearer here than in the case of neurotic traits. In our material it covered a wide range of maladjustments in interpersonal relationships, from rather serious cases of juvenile delinquency found in the juvenile court and on the police dockets to the less severe forms usually recorded by social agencies and psychiatric clinics. It will be noted in Table 2 that there were 371 individuals who presented conduct problems, but that it was the leading classification in only 311 of these cases. The other 60 were children with both neurotic traits and conduct problems.[1] All tabulations relating to the group of conduct problems will apply to the total group of 371 rather than to the 311, and the same principle will be applied all the way down the "hierarchy."

The next diagnostic group, designated in Table 2 as "minor personality traits," includes the cases of "minor or possible disorders" of the general classification minus the eight "nervous in census" who were included in the group with neurotic traits, as mentioned above. Our records note certain rather vague personality traits in these children, but their complaints were of too minor a nature, or the information on them was too scanty, to justify their inclusion in the group with more definite neurotic traits. Most of these cases were picked up in the psycho-educational clinic of the public-school system. In view of the vagueness of the concept and the smallness of the sample, this group will not be further analyzed.

The general problems of epilepsy and mental deficiency were discussed in the third paper [2] of this series. As we have noted earlier, the dividing line between mental deficiency and border-line intelligence was arbitrarily drawn at I.Q. 70, in conformity with official usage.[3]

[1] Theoretically some of them could also have been combinations of psychosis with conduct problems, but no such case happened to be in our material.

[2] See MENTAL HYGIENE, Vol. 26, pp. 275–88, April, 1942.

[3] See *Statistical Manual for the Use of Institutions for Mental Defectives*, prepared by the Committee on Statistics of the American Association on Mental

The last group, therefore, described as "school-progress problems without mental deficiency," includes mostly cases in which the I.Q. ranged from 70 to 89. Only a few in the group were able to achieve a normal (I.Q. 90–109) test performance, and the possibility cannot be excluded that in those cases some personality disorder remained unreported. Some difficulty of progress in school was reported in 54 children for whom this was the only fact available, no intelligence rating having been recorded by the source. A few of these may actually be mental defectives.

Parenthetically, it may be mentioned that I.Q.'s were available for all but 15.6 per cent of the 1,242 children included in this report.

The type of record at the disposal of our study does not permit the calculation of true incidence rates, indicating the numbers of new cases per year per unit of population, or of prevalence rates, giving the numbers simultaneously active on one particular day. The complexities of this problem were outlined in the first paper of this series. Suffice it to say that a compromise had to be made in the form of one-year prevalence rates, indicating the numbers of cases active at any time throughout the year. In the case of permanent or relatively permanent conditions such as mental deficiency and epilepsy, this one-year rate is practically equal to the one-day prevalence figures. All rates presented in this paper are based upon the total number of cases found in each category, except those for family income, which are necessarily limited to children identified with individuals or households in the census.

Table 3 presents the group of children with neurotic traits. The total number thus classified was 140, which is 2.5 per 1,000 of the total population of all ages. For "adult neurotics" a rate of 7.7 per 1,000 was found.[1] These rates give an impression of the relative magnitude of the problem of adult and childhood neurotic behavior in terms of numbers of cases recognized in this community. The rates do not, however, give any information as to the relative frequency of neurotic behavior in the two age groups per unit of popula-

Deficiency in coöperation with The National Committee for Mental Hygiene. Utica, New York: State Hospitals Press, 1941.

[1] See MENTAL HYGIENE, Vol. 26, p. 117, January, 1942.

TABLE 3.—DISTRIBUTION BY RACE AND SEX OF 140 CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS WITH NEUROTIC TRAITS

	Number of cases	*Rate per 1,000 of the population*	*Standard error*
White males	58	14.2	1.8
White females	58	14.7	1.8
Negro males	12	9.3	2.6
Negro females	12	8.9	2.6
All whites	116	14.5	1.3
All Negroes	24	9.1	1.9
All males	70	13.1	1.5
All females	70	13.3	1.5
Total	140	13.2	1.1

tion of the same age. Of the children, 13.2 per 1,000 showed neurotic behavior of some sort; the corresponding figure for adults aged twenty-five and over was 12.4 per 1,000. From the purely statistical point of view, the difference between the juvenile rate and the adult rate is not significant.

No hasty conclusions, however, should be drawn from this fact. What has been said above about the different standards used for adults and children is particularly true of the two groups designated by the terms "neurotic" and "neurotic traits." In the section on the index of case finding[1] an attempt was made to evaluate the coverage of the survey for certain groups of mental-hygiene problems among adults. We see no way at present to develop a similar index for the school-age group, but it is our belief that behavior patterns classifiable as "neurotic" are very common among children and that the total number of "cases" occurring over the survey year was probably very much larger than the number that came to the attention of our sources. Furthermore, the equal magnitude of the rates can in no sense be interpreted as meaning that the children now called neurotic will later be psychoneurotic adults.

The outstanding facts concerning the race and sex distribution of the children with neurotic traits are to be seen in Table 3. The white rate is higher than the Negro rate by 5.4 per 1,000, which is 2.35 times the standard error. This

[1] See MENTAL HYGIENE, Vol. 26, pp. 284–88, April, 1942.

relationship is the same as that found for the "adult neurotics." The difference between sex-specific rates, on the other hand, is negligible for the children, whereas a large excess of females is perhaps the main demographic characteristic of the "adult neurotic" group. The distribution of cases over the ten-year span from seven to sixteen, inclusive, is fairly even, the median age being 11.6 years. For 88 per cent of the group an intelligence rating is on record, indicating a median I.Q. of about 82.

TABLE 4.—PROBLEMS PRESENTED BY 140 CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS WITH NEUROTIC TRAITS, BY SEX AND RACE

	Males	*Females*	*Whites*	*Negroes*	*Total*
Temper tantrums	15	19	29	5	34
Enuresis	16	15	23	8	31
Fears	11	15	18	8	26
Speech and reading defects	19	4	19	4	23
Nail-biting	11	9	17	3	20
Overactivity	7	8	15	–	15
Sleep disturbances	7	7	12	2	14
Feeding problems	3	5	8	–	8
Masturbation	6	1	7	–	7
Tics and habit spasms	2	4	6	–	6
Vomiting	2	4	5	1	6
"Nervousness"	15	21	32	4	36
Other	8	11	16	3	19
Total problems	122	123	207	38	245
Total cases	70	70	116	24	140

In order to get somewhat better insight into the heterogeneous group of children with neurotic traits, the problems presented by these children were tabulated. They are presented in Table 4. The total number of problems—perhaps it would be better to say "complaints"—listed is 245 in the 140 children. In 63 cases, only one complaint was found in the records; in 49 cases, two; and in 28 cases, three or more. For purposes of tabulation, however, only the three most outstanding problems were listed for any case. The number of problems per case appears to be the same in each of the sex and racial groupings.

The categories in Table 4 are largely self-explanatory and require little elaboration. "Fears" includes a few cases of physical preoccupation; "nervousness" covers other general

terms such as instability; and "other" is again the catch-all for a number of complaints presented by just a few children and for some otherwise unassignable problems.

Unfortunately, most of the groups are too small for statistical analysis. It can be stated, however, that the group with speech and reading defects is the only one that shows a significantly skew sex distribution. There were 19 boys as against 4 girls in this category. There is much less than one chance in a hundred that this is a result of sampling variation.

There was a deficiency of Negroes in all groups—with the statistically insignificant exception of "fears"—and in no group was the percentage of colored cases found to deviate significantly from the ratio established for all problems as a group. The distribution of the 245 problems among the 140 cases seems to be fairly random; there seem to be no combinations of problems that tend to appear simultaneously in a recurring pattern.

Only a tentative interpretation of these findings will be made at this time. It is felt that the apparently equal prevalence of "neurotic traits" among boys and girls of school age may be accepted at face value because problems of this kind seem to have the same chance of coming to the attention of our sources in male and in female children. The uniformity of the sex distribution in almost all the problem groups gives the impression that these behavior patterns are specifically "juvenile," characteristic of an age period of incomplete biological and sociological sex differentiation, not necessarily the forerunners of adult neurotic manifestations.

The lower rates among Negroes, both in the juvenile and in the adult group of neurotics, present a knotty problem of interpretation. The colored population of the Eastern Health District is in general better covered by clinics and social agencies than the more prosperous white population. This would indicate that the lower Negro rate represents the facts correctly. On the other hand, there is a possibility that some "neurotic" behavior patterns in colored children may be accepted as normal both by the Negro parents and by the white social workers who work with them; clinical experience shows that Negro parents tend to subject their children to less anxious scrutiny than do white parents.

Table 5 presents the distribution by race and sex of the children with conduct problems. These cases numbered 371, or almost one of every 30 children living in the Eastern Health District. The race and sex differences are marked and are highly significant statistically. The Negro rate is higher than the white rate by 29.4 per 1,000, which is 5.95 times the standard error; and the male rate exceeds the female rate by 34.7 per 1,000, with a critical ratio of 9.68.[1]

TABLE 5.—DISTRIBUTION BY RACE AND SEX OF 371 CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS WITH CONDUCT PROBLEMS

	Number of cases	*Rate per 1,000 of the population*	*Standard error*
White males	167	41.0	3.0
White females	54	13.7	1.8
Negro males	112	87.2	7.9
Negro females	38	28.2	4.5
All whites	221	27.6	1.8
All Negroes	150	57.0	4.6
All males	279	52.1	3.1
All females	92	17.4	1.8
Total group	371	34.9	1.7

The sex ratio is about the same for white and for colored children. The median age of the group is 13.5 years, which is higher than that of the children with neurotic traits, and which indicates a concentration in the upper half of the ten-year span.

Intelligence ratings were on record for about two-thirds of the cases. For the individuals with known I.Q.'s, a median

[1] The critical ratio is the difference between two values divided by the standard error of this difference. It is a measure of statistical significance. The probability that a given difference is a chance result decreased very rapidly with increasing critical ratio. This is shown below. Differences with a critical ratio of less than 2 are described as insignificant in this series of papers.

Critical ratio	*Probability of chance result*
2.0	One in 22
2.5	One in 80
3.0	One in 370
4.0	One in 16,000
5.0	One in 1,750,000

value of approximately 77 was ascertained, which is somewhat lower than in the group with neurotic traits.

An anlysis of the specific conduct problems presented by the whole group of 371 children in given in Table 6. The total number of problems tabulated is 501, or 1.35 per case. This ratio is about the same for all sex and race groups. It should be noted that an individual is listed only once in any class of problems regardless of the number of times he is reported to have exhibited the behavior pattern in question.

TABLE 6.—CONDUCT PROBLEMS PRESENTED BY 371 CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS, BY SEX AND RACE

	Males	*Females*	*Whites*	*Negroes*	*Total*
Violence against persons.....	14	1	9	6	15
Stealing	105	8	58	55	113
Miscellaneous delinquency....	111	25	68	68	136
Truancy	62	27	52	37	89
Other school misbehavior.....	64	20	66	18	84
"Other problems"	29	35	44	20	64
Total problems	385	116	297	204	501
Total cases	279	92	221	150	371

The excess of problems over cases, therefore, indicates multiformity rather than repetition of complaints. The preponderance of the male sex and the overrepresentation of the colored race are evident in most groups. Both are very marked for stealing and miscellaneous delinquency. Most of these cases were found in the records of the juvenile court. The sex and race differentials are much less noticeable in the figures for truancy and other school misbehavior, children of both races appearing in the latter category in the same proportion as in the general population—that is, three whites to one Negro. In the group called "other problems," which includes family maladjustment, sex problems, and so on, the observed differentials are statistically not significant.

The fact appears fairly well established that juvenile conduct problems appear more frequently in the male than in the female sex, at least in the extrafamilial sphere. Boys get into more trouble with the law and the law-enforcing agencies, and their breaches of school discipline tend to be more dramatic and offensive. This may be due to constitutional

differences in the two sexes as regards this pattern of behavior, or it may be due to a difference in the matter of opportunity for such reactions. In so far as the sex difference for intrafamilial conduct problems is less marked, it may be that the social factor is to be emphasized rather than the constitutional.

To consider the problem from a psychodynamic point of view, it is interesting to speculate whether the greater opportunity for aggressive reaction among males of this age may not account for the fact that among adults males show markedly fewer neurotic reactions than do females, a fact demonstrated in the second paper of this series. It has also been noted that the boys and girls of this age group show equal vulnerability to neurotic disorders. Conduct disorders show a heavy predominance of males. This would lend support to a view that conduct disorders and neurotic disorders are in some way intrinsically different, and would suggest that the grouping of the two together etiologically and therapeutically, as is so often done, calls for reconsideration.

The large excess of Negroes over whites must not be interpreted as an indication of a special propensity for juvenile misconduct in the colored race. As has been demonstrated, the concentration of Negroes in the lower-income brackets makes for better coverage by our sources. In addition there can be little doubt that the opportunities for conflict with the law, and, to a lesser extent, also with the school authorities, are multiplied for children from indigent homes located in poor neighborhoods. Many a case of broken windows and stolen apples never reaches the juvenile court if the culprit comes from a "nice" home and the damage is repaired out of the parental pocketbook. Race antagonism in contact areas between whites and Negroes intensifies this type of bias. Furthermore, the schools in the district are very much less well supplied with special classes for colored pupils with low I.Q.'s than for white. This factor probably tends to raise the Negro rates of delinquency. To anticipate the results of a tabulation by family income to be given in Table 10, it may be stated that juvenile conduct problems are known to occur only a little oftener among Negroes than among whites in a comparable financial situation. The conclusion appears justified that the higher rate for the Negroes as a group is chiefly due to differences of social-economic status.

TABLE 7.—DISTRIBUTION BY RACE AND SEX OF 40 CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS WITH EPILEPSY

	Number of cases	*Rate per 1,000 of the population*	*Standard error*
White males	14	3.4	.9
White females	9	2.3	.7
Negro males	12	9.3	2.6
Negro females	5	3.7	1.7
All whites	23	2.9	.6
All Negroes	17	6.5	1.6
All males	26	4.9	.9
All females	14	2.7	.7
Total group	40	3.8	.6

The race and sex distribution of the epileptic children is presented in Table 7. As was to be expected, the prevalence rate is higher than for the total population of all ages, where it was found to be 2.3 per 1,000. This is due to the facts that epilepsy is rarely diagnosed before the age of seven, that some cases get well, and that many die before the age of seventeen. The Negro rate exceeds the white rate by 3.6 per 1,000, with a critical ratio of 2.10; the sex difference is statistically not significant. The group appears too small to warrant further analysis.

Our material included 403 mentally deficient children in the age group seven through sixteen. The prevalence rates shown in Table 8 compare reasonably well with the rates

TABLE 8.—DISTRIBUTION BY RACE AND SEX OF 403 CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS WITH MENTAL DEFICIENCY

	Number of cases	*Rate per 1,000 of the population*	*Standard error*
White males	113	27.8	2.5
White females	74	18.8	2.1
Negro males	130	101.2	8.4
Negro females	86	63.9	6.8
All whites	187	23.4	1.7
All Negroes	216	82.1	5.4
All males	243	45.4	2.9
All females	160	30.3	2.4
Total group	403	37.9	1.8

found in the great mental deficiency investigation in England [1]—namely, 20.9 per 1,000 among urban and 39.7 per 1,000 among rural children of school age. Of the 403 mental defectives in our study, 351 were classified as morons. This was a somewhat higher proportion than is usually found. There were 32 imbeciles and 11 idiots. In nine cases the degree of the deficiency had not been ascertained.

Taking the group as a whole, we find race and sex differentials similar to those noted for the children with conduct problems. The Negro rate exceeds the white rate by 58.7 per 1,000, with a critical ratio of 10.37. The male rate is higher than the female by 15.1 per 1,000, which is 4.02 times the standard error. In our material, sex and race distribution for the various grades of deficiency are not significantly different.

It may be mentioned in passing that in 15 cases of mental deficiency, brain damage was clearly indicated, and in two more cases such damage was suspected. Nine of these children were idiots or imbeciles.

The question arises whether the unequal numbers of males and females in our material are due to an intrinsically different distribution of intelligence, as measured by test performance, or whether selective case finding may be at least partly responsible. It seems possible that boys on the moron level are more difficult to handle in the regular grades than girls of equal intelligence, and that they are, therefore, more heavily represented among pupils of the special classes and in the psycho-educational clinic of the public-school system, which is often consulted with a view to placement in a special class. Youngsters seen and tested at the juvenile court are of course much more likely to be boys than girls. If this biasing factor is of any importance, it would mean that the prevalence rate for females is fallaciously low.

The race difference that appears in the prevalence rates for mental deficiency indicates a difference of about ten points in average I.Q. between whites and Negroes. This is not at variance with the findings of other investigators in the field. It will be seen that a race difference is also found

[1] See *Report of the Mental Deficiency Committee, Being a Joint Committee of the Board of Education and the Board of Control*, Part 4. London: H. M. Stationery Office, 1929.

between groups of approximately comparable economic status. Our study cannot offer any contribution to the controversy about the underlying factors behind the race difference in intelligence as measured by tests. We feel reasonably safe in stating, however, that the educational opportunities offered to white children in Baltimore are superior to those available to Negroes.

The race and sex distribution of the 592 children with school-progress problems without mental deficiency, as presented in Table 9, shows some remarkable features. There

TABLE 9.—DISTRIBUTION BY RACE AND SEX OF 592 CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS WITH SCHOOL-PROGRESS PROBLEMS WITHOUT MENTAL DEFICIENCY

	Number of cases	*Rate per 1,000 of the population*	*Standard error*
White males	301	73.9	4.1
White females	180	45.8	3.4
Negro males	73	56.8	6.4
Negro females	38	28.2	4.5
All whites	481	60.1	2.6
All Negroes	111	42.2	4.1
All males	374	69.8	3.4
All females	218	41.3	2.8
Total group	592	55.7	2.3

is a sex difference in the same direction as that found for the mental defectives and of a similar order of magnitude, but the race ratio appears reversed. The white rate exceeds the Negro rate by 17.9, with a critical ratio of 3.69. Such a relationship seems to be highly improbable. It can best be explained by reference to the fact that special classes are provided to a lesser extent for colored than for white children and that therefore most border-line Negro children have to be carried in the regular grades. This is illustrated by the following figures on children from the Eastern Health District enrolled in special classes in 1936. Of the white children, 27.2 per cent had I.Q.'s of less than 70, and 72.8 per cent, I.Q.'s of 70 or more; for Negroes the corresponding ratios were 72.6 and 27.4. These figures show that the Negro child must have a much more severe deficiency to be admitted to a

special class than the white child, and that special education is not available for colored children of "border-line" intelligence. In view of these gross deficiencies, further analysis of the group with school-progress problems without mental deficiency will not be undertaken.

TABLE 10.—DISTRIBUTION BY FAMILY INCOME OF WHITE AND NEGRO CHILDREN AGED SEVEN THROUGH SIXTEEN YEARS* WITH NEUROTIC TRAITS, CONDUCT PROBLEMS, AND MENTAL DEFICIENCY

Family income	*With neurotic traits*		*With conduct problems*		*With mental deficiency*	
	No. of cases	Rate per 1,000 of the population	No. of cases	Rate per 1,000 of the population	No. of cases	Rate per 1,000 of the population
Whites:						
Relief	24	22.1	57	52.4	38	34.8
Non-relief under $1,000	32	13.1	59	24.2	66	27.1
$1,000 to $1,500	23	9.2	48	19.3	26	10.4
$1,500 to $2,000	11	8.3	15	11.4	21	15.9
$2,000 and over	5	8.9	3	5.3	8	14.2
	95		182		159	
Negroes:						
Relief	10	8.4	73	61.2	99	83.1
Non-relief	8	5.6	49	34.1	79	54.9
	18		122		178	

* Excluding non-census individuals and cases in which family income was unascertained.

The data on the distribution of juvenile mental-hygiene problems in relation to relief status and family income have already been mentioned. They are presented in Table 10. It should be remembered that these figures cannot be directly compared with all others in this paper because they exclude non-census individuals whose economic status could not be determined. The tabulation has been carried out for three groups of children only—those with neurotic traits, those with conduct problems, and those with mental deficiency. In general, the rates fall as the income rises. This fall, which appears most marked in the group with conduct problems, is probably to a considerable degree due to better coverage of the economically poorer classes by social agencies and clinics. Whether there is a genuine fall with rising income, we do

not know. It seems probable that there is, especially in the case of mental deficiency and conduct problems that manifest themselves in the extrafamilial sphere.

For purposes of comparison between the two races, the non-relief Negroes may well be equated with the non-relief whites with family income of less than $1,000 in 1936. In this group, as well as among the relief families, a statistically significant white excess appears for neurotic traits and an even higher Negro excess for mental deficiency, but there are no significant differences in the case of conduct problems. These relationships have already been mentioned earlier in this paper and possible interpretation of the findings has been given in connection with each group of problems.

SUMMARY

1. This fourth of a series of papers on the prevalence of mental-hygiene problems in an urban district presents data for the age group seven to sixteen, inclusive.

2. Neurotic traits occurred at a rate of 13.2 per 1,000 of the population of the same age. They were equally divided between the sexes, but were found significantly more often among white than among Negro children.

3. Conduct problems were reported for 34.9 per 1,000 of all children. They were much more frequent among boys than among girls and among Negroes than among whites.

4. We offer the suggestion that the differences in demographic pattern between neurotic traits and conduct problems indicates that the grouping of the two together etiologically and therapeutically may be questioned.

5. Epilepsy appeared in children of school age at a rate of 3.8 per 1,000 of the population of the same age.

6. Mental deficiency was recognized in 37.9 per 1,000 of the population of corresponding age. A higher rate was found for the male than for the female sex and for Negroes than for whites.

7. Neurotic traits, conduct disorder, and mental deficiency all appear to be correlated inversely with family income.

BOOK REVIEWS

LOVE AGAINST HATE. By Karl Menninger, M.D. New York: Harcourt, Brace, and Company, 1942. 311 p.

Man, in his struggle to deal comfortably with his consciousness of the fact that he is man and not beast, has got himself into all kinds of trouble. Not the least is his flight from the happier elements of his beasthood and his correlative maldirection of the elements of hostility and aggression in his nature. Menninger deals with the factors in this struggle in a combined philosophical and scientific presentation, and offers some concrete views on the directions that should be followed in the solution of the quandary.

He begins with a presentation of the frustrations that are unnecessarily imposed on the child by the convenience, misunderstanding, or neurosis of the parent (the mother), particularly in the matter of premature habit training. He shows how this brings about in the child a confusion of love and hate that continues throughout life and that bears down a generation later on the new babies that come along. Specifically, he implicates interference with the innate tendencies of the child, such as sucking, excretion, cuddling, and growing individuation. He throws light on some of the conditions of our culture and our interpersonal relationships that turn potential plus values of life for women into minuses, conditions arising both from the surroundings and from the woman herself. He considers particularly the blanketing of the sexual function in both sexes.

He proposes to interrupt this vicious circle of the generations, in which hostile aggression begets hostile aggression, by a more adequate pursuit of work and play, and by love strengthened by faith and hope. His discussion of religion and its value is especially meaningful to those of us who have seen patients struggle to create homemade religions when the formalized religions failed to meet their need. He points out that in the normal person aggressive energy is in part repressed, in part expressed in altruistic efforts, in part sublimated, in part turned into a function of conscience. His hinting at the ways in which our distrust of our own aggressions is met and sometimes shackled in our culture calls to mind that certain humanitarian movements, such as the prevention of cruelty to animals, is basically a shackling of our own aggressive tendencies, that they may not overwhelm us.

His solutions of work and play are of course not new, but his discussion gives them a rationale in the managing of aggression that

makes it easier to accept them as something other than meeting economic needs and passing time. His chapter on play is particularly good from this angle, and should be read by all persons in the field of recreation. In elaborating the remedy of hope, he focuses especially on the plight of the child and inspects education in the light of the pronouncements of educational philosophers on the one hand and practitioners on the other.

Any one who reads this book in order to get Dr. Menninger's advice as a blue print for life is wasting his time. For one who reads, feels, identifies, and at times disputes or contradicts, its pages will be now a sedative, now a stimulant, and now an alterative. They may be true and false at the same time, depending upon who is doing the reading, but the falsity will not be a liability because it will be recognized and ignored, if gross, and accepted as seasoning if it is merely hyperbole. There are of course preoccupations with single factors when in reality a situation may be multi-determined, but every treatise of this sort should be expected to state points of special interest in relief, and the reader is poorly appointed if he approaches his reading ignorant of this fact. For myself, I cannot see much in the book to disagree with.

GEORGE S. STEVENSON.
The National Committee for Mental Hygiene.

RELIGION IN ILLNESS AND HEALTH. By Carroll A. Wise. New York: Harper and Brothers, 1942. 279 p.

In his preface, the author states that this book is designed not only for clergymen, but for psychiatrists and social workers. The scope of the book is so great that it is doubtful whether readers without a clinical background and without definite concepts about the dynamics of human development can follow Dr. Wise far.

The book is divided into two sections. The first—*Illness and Health in the Light of Modern Knowledge*—reviews very ably our current ideas of the dynamics of psychosomatic difficulties and the psychoses. In Chapter IV, the integration of biological and psychological development is stressed. The author finds it important that the psychobiological whole has potentialities greater than the sum of its parts. The point is made also that the environment does not act passively upon the individual, but is re-created and acted upon also.

The second section—*Religion in Illness and Health*—presents a wealth of material about the use people make of religion in their own development. It has practical advice for the clergyman at the bedside of a sick or psychotic person. It makes a real differentiation between religion as a cultural dogma and ideal and religion as it is used negatively and positively by the individual. It suggests the

possibility that religious symbolism may carry many values from every area of life and not be most authentically religious.

In part of this section, however, the author gets involved in a semantic controversy as to what is reality and what is illusion. That is, having accepted the view that the character of religious feeling is a projection, in that content, of the way a person feels about himself, one does not seem justified in seeing repressed, negative persons as having the wrong symbols of religion (a semantic or educational defect). It seems inconsistent.

Perhaps the great difficulty in writing this part of the book, and the reason it seems to wander at times, is the protean use to which human beings put religion as a feeling and as an institution. The various parts played by religion are mentioned in a wealth of detail. The identification with it as a love object, the struggle with it as an external force, are presented with vividness.

In closing, the author invites clergymen to separate themselves from their own beliefs and their anxiety to support religion, and to restudy it as it lives in the individual. He feels that religion needs no support, as it will go on as long as people must develop and live together. This may be so, but people have always demanded that the clergy represent the institution of religion symbolically, as the author says; and this symbolic representation means a clear dogma. It is almost impossible to stand sincerely for an ideal dogmatically represented and yet to study the individual use made of the symbol.

This is a scholarly and a thought-provoking book on an extremely difficult and touchy subject. There is a profound problem of organization of material in it which the author did not entirely solve. It is worth-while reading, but difficult.

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SCIENCE AND SANITY: AN INTRODUCTION TO NON-ARISTOTELIAN SYSTEMS AND GENERAL SEMANTICS. By Alfred Korzybski, M.D. Second edition. (The International Non-Aristotelian Library.) Lancaster, Pa.: The Science Press, 1941. 806 p.

In the formulation of "general semantics," Count Alfred Korzybski has set out on no small task. An examination into the real nature of personality disorder, even if fruitful, might lose itself in a field nearly illimitable and nearly bottomless. When the author proposes to extend such an examination into the causes of war and poverty, of social inadequacy and human unhappiness, the reader may become skeptical before he starts, and feel that efforts, however bold and wise,

directed so ambitiously and on a scope so vast will disperse themselves and end in little that is substantial. Should it be proposed also to devise a scheme for dealing successfully with the chief disorders and miseries of mankind—a scheme involving a new interpretation of human experience, of the "world," and of life itself—the prospective reader is scarcely to be wondered at if, going no farther, he shrugs his shoulders and decides not to waste his valuable time participating as a spectator in such cosmic tilting with windmills. One can scarcely blame him if he should forthwith decide that this tilting must be of the sort more appropriately carried out in the privacy of a psychiatric hospital than in print for public consumption. Such a prospective reader would, however, in the reviewer's opinion, make a most serious mistake.

In *Science and Sanity* Korzybski actually attempts nothing less than the staggering tasks we have mentioned. He attempts to define true madness, but insists that what psychiatrists deal with at the clinical level is the product or the expression of something much broader and much deeper, a false evaluation of experience, a delusional interpretation of man's functions and of his surroundings, which is drilled into all people during their training or education at schools and elsewhere. The cliché to the effect that every one is probably somewhat mad has become so shopworn that one seldom meets it now except among people of little ingenuity who are seeking to make conversation. But never to the reviewer's knowledge has any one except the author of *Science and Sanity* taken seriously and literally this usually flippant or shallowly cynical quip. Korzybski presents some impressive evidence to the effect that madness consists largely of false knowledge deliberately taught—taught in the full sense of being built into the general working of those neural activities which are associated with personality reactions—and that this false knowledge is of a sort that makes almost inevitable a way of living that is far from sanity.

The formulations of Euclid were adequate for the geometrical facts available to Euclid, but they are not adequate to-day. So Newton's mathematical language, although "true" for the phenomena of physics that were measurable at the time, contains serious fallacies that prevent it from correctly describing what the physicist of to-day observes. In the same way the logic of Aristotle and the entire Aristotelian system helped man appraise more accurately himself and his relations to the external world two thousand years ago. Korzybski maintains, however, that the formulations of Aristotle are grossly inadequate to-day. These formulations furthermore, in comparison with those of Euclid and of Newton, enter much more deeply and more extensively into the daily life and the practical

activities of mankind, shaping and determining our present language and culture, our basic notions of fact and value, and our reactions to experience. The map (language) by which we try to explore the territory (our actual experience and the experience of others) is scarcely more accurate than a map of the United States in which Chicago is placed on the west coast, San Francisco on the east coast, and New York somewhere between.

Korzybski points out many specific defects in the Aristotelian system in which we are still trained and by which we try to live. Among these is the fact that Aristotelian logic is two-valued. In a two-valued logic one is continually confronted with the choice of *either . . . or* and of no other choice. While this may be "logical" and accurate at verbal levels, it is by no means always applicable to the structure of the world or to human experience. In accordance with this two-valued logic, many elementalistic terms are applied to things that do not exist separately in experience, and artificial contrasts and imaginary distinctions are made (such, for instance, as pronouncing reactions "intellectual" or "emotional"). Consequently man finds his experience baffling and men argue "logically" with one another, coming, however, not to agreement, but to rage, frustration, and the conviction that the other fellow is a fool or a rascal.

In the Aristotelian system, and in our life and functioning, the "is" of identity is taken seriously and literally, and man is thus grossly deceived into identifying his definitions with objects and events without regard for important differences, not only between chair_1 and chair_2 (or sweetheart_1 and sweetheart_2), but also without proper regard for the serious difference between first-order experiences and abstractions.

This universal, or all but universal, practice of identifying abstractions with objects and events is carried out without insight, without consciousness that one is abstracting. As an example of the misunderstandings that arise here, one need only recall the bitterness and vehemence of arguments between persons who proclaim their knowledge of "God" in terms implying a definite, objective being, with the attributes of a man, and persons who scoff at such beliefs as superstition. A common inability to distinguish between abstractions and objects is not unnatural, since in our language, in our logic, and in the ordinary means we have for evaluating experience, these are confused. It is difficult, if not impossible, for the man living in 1943 to attain consciousness of abstracting within the Aristotelian system; consequently he grows to rely on verbal arguments that have little connection with first-order experience or with the actual world. One who lives largely at a verbal level relies on what has long been recognized by psychiatrists as "rationalization." In his

continual recourse to abstractions and evasive verbalization, he may lose touch with first-hand living to such an extent that he fails to participate adequately in experience as a human being.

An extreme example of treating verbal processes as if they were experience itself was recently observed by the reviewer in a case of schizophrenia. This patient persistently looked down at the floor and aside from the examiner during the interview. On being requested to look directly at the physician, she readily complied in words. "Why, certainly," she agreed time after time. Her eyes remained, however, staring at the floor, so directed that she could not see the physician at all. No matter how often or persuasively she was urged to face the physician, she did not change her gaze in the least. Each time the request was made, she spoke agreeably and it was plain that she considered herself as having carried out the act in her verbal consent to do so. She finally became impatient with requests, insisting repeatedly, "I'm looking right at you, Doctor." The fact that she had not shifted her eyes from the floor did not interfere with the verbal manipulations by which she believed that she had complied.

The aim of general semantics, as set forth in *Science and Sanity,* is not merely to make changes in the language we use, but to bring about a sweeping and profound reorientation that will avoid the faulty personality reactions and the underlying faulty neurologic reactions that develop through training within the Aristotelian system. Korzybski speaks of cortical and of thalamic reactions, making it clear that he is not assigning such functions specifically to these neural areas, but is using the terms schematically. The use without insight of a language and a logic that falsify the actual data of experience leads, he maintains, to inadequate reactions in which the process fails to go all through the nervous system, so to speak, but consists in a merely cortical response (as in the verbal compliance of the patient cited above) or at other times in a merely thalamic response, as, for instance, in the impulsive and ill-considered rage of a manic case. Korzybski advocates a thorough retraining, not merely on verbal levels, but with practices involving actual sensory experience, to bring about properly integrated semantic reactions (personality reactions).

We stated at the beginning of this review that the author of *Science and Sanity* undertook no ordinary task. How well has he succeeded? The reviewer believes that he has made a truly remarkable statement in the field of psychopathology, that he clearly and convincingly formulates the dynamic processes that underlie clinical personality disorder. To formulate this psychopathology it is necessary to pursue the inquiry not only into the fundamentals of our education and culture, but into the very structure of our language and

logic. The reviewer is convinced that Korzybski's inquiry really gets at the root of many serious impediments to progress, to happiness, to normal functioning in persons and civilization—to what he aptly calls sanity.

Science and Sanity offers a remedy for the disorder that it describes. Definite and detailed methods are discussed by which the young may be taught to avoid the faulty reactions produced by the Aristotelian system and by which adults, already confused and limited and frustrated by improper semantic reactions, can be retrained and reoriented. The solution suggested is not, of course, in the form of a simple magic panacea or a Messianic miracle, but involves hard and persistent work. If the solution is to be applied on a large scale, it would, of course, demand the introduction of new methods generally into education and training and other tremendous collective efforts. If, however, humanity is to progress toward greater sanity, the reviewer is convinced that this progress will be by just such steps as those pointed out with such admirable clarity and emphasis by Korzybski.

There is much in *Science and Sanity* that may arouse adverse criticism. The neuro-physiologist and perhaps even some psychiatrists may complain that the author is not justified by scientific fact in his interpretation of thalamic and cortical functions and of cortico-thalamic integration. Korzybski, however, plainly states that he is using these terms merely schematically to represent neural processes that apparently enter into personality reactions. Such criticism impresses the reviewer, not only as invalid, but as an example of what is so well described in the book—the identification of abstractions with objects. Korzybski seems well aware that he is abstracting, and this criticism emphasizes the limitations imposed by the Aristotelian confusions he is seeking to eliminate.

Some might also object to the author's use of "thalamic" as opposed to "cortical" and accuse him of falling into the very elementalism or artificial dualism which he deplores. This objection again seems to be little more than empty verbalism or casuistry, for it is hard to believe any fair reader could fail to see that a man so thoroughly acquainted with the dangers of taking literally the word "all" would say that any human reaction is *all* thalamic or *all* cortical.

Many will perhaps feel that general semantics is not entirely original. In a sense, this is probably true. Persons who make progress in the various fields of science and who create genuine products in any of the arts (the real poet is extensional and avoids generalizing, intensional language) no doubt escape in various degrees the limitations and blockages attributed by the author to the Aristotelian system. Any person who achieves sound happiness in his living might be said to have learned something of what is

presented as general semantics. This is not to say, however, that the material contained in *Science and Sanity* was available elsewhere. This particular interpretation of man's failure to achieve general sanity and the formulation of a non-Aristotelian system impress the reviewer not only as a Herculean feat, but also as a feat of remarkable originality.

In small matters within the field of medicine some statements seem too sweeping. On page 105, for instance, one finds the following: "It is not a novelty that a moron cannot be 'insane.' A moron lacks something; only the more gifted individuals, the more human (as compared with animals), break down." Morons, of course, do become psychotic and successfully confute the quotation above. The argument for which this exaggeration is introduced makes, nevertheless, an important and valid point.

The reviewer feels it is little short of astonishing that this book, written in the English language—which like other national languages, has for most of us all the implications and errors and false assumptions of the Aristotelian system—succeeds so well in formulating Korzybski's larger and more flexible system.

Science and Sanity is strongly recommended, to psychiatrists and to teachers particularly, but also to the general public. It is not a book to be chosen for the whiling away of idle hours, but whoever reads it with proper care and energy is likely to have an experience of real moment. It is interesting to speculate on what might follow if, say, a hundred thousand of the most influential persons in the United States would acquaint themselves thoroughly with *Science and Sanity*.

Ordinary insight leaves the reviewer too well aware of his limitations to make a sweeping, dogmatic judgment on a question of such moment, but it is suggested that this book may prove to be one of the great and few landmarks of human progress.

HERVEY CLECKLEY.

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Augusta.

FOUNDATIONS FOR A SCIENCE OF PERSONALITY. By Andras Angyal, M.D. New York: The Commonwealth Fund, 1941. 398 p.

In ten chapters (and a nine-page epitome) Dr. Angyal gives a brilliant outline for the synthesis of the various disciplines into what he terms an holistic approach to the study of the personality. If one feels that he has, instead, managed to set up one set of ordinates against which data of various kinds can be measured, this does not take away from the notable character of his contribution. One finds some new words, because the more familiar are too brittle for reori-

entation, but each chapter's excellent summary and the final epitome more than balance that amount of strangeness.

Through the first part of the book the total biological process is presented as a trend toward autonomy—as the ever-growing area of the personality's domination over its own fate (Chapter II). In terms of efficiency, this demands increasing symbolization (Chapter III). There has been a growing effort to depict the organism and its environment as but different aspects of a unit; Chapter IV is as good a development of this view as I have seen. As the development of autonomy demanded a discussion of psychological functions (of which symbolization was a central theme), so this dynamic definition of the relation of the individual to the environment requires a chapter (Chapter V) on "biospheric dynamics." It offers a compelling invitation to a far-flung group of sciences to see their data in terms of the biosphere (the realm in which the biological total process takes place) as a system of tensions.

Chapter VI is perhaps the best in the book. After the author has built a compact, water-tight system about the organism's trend toward autonomy, he finds himself faced here with its equally compelling trend towards homonomy—its need to lose itself in the social group. The book loses its neatness; Dr. Angyal squirms a bit; he seems to want to say that somehow it all ought to be a bit simpler than it now turns out to be. Perhaps an hypothesis ought to be simple and clear —but the clinician warms to the acknowledgment of cross-currents. All other readers, too, will find this chapter a relief from the rather cold certainty with which the rest of the volume moves.

The last four chapters give a glimpse of what might be termed the practical application of the theories thus far presented. This perhaps does poor justice to what is really a further development of these theories—but, even more than in the earlier part of the book, the reader will be constantly saying, "Now I see where such and such might fit it." The discussion of the problem of integration (Chapters VIII and IX) and of the course of life as a Gestalt are particularly good. Even if the Gestalt group has written considerably on this latter subject (the reviewer is uninformed on this point), Chapter X would remain an outstanding exposition of the consideration of the total life process as a Gestalt. It's well worth reading.

Atomistic approaches to "personology" have developed whole areas of what seem to be vested interests. One feels somewhat sadly that this brave and far-sighted effort at synthesis will meet with much acclaim, but will effect little practical change in attitude or approach. That a science of personality is needed, seems perfectly clear. That, at the present time, we need to correlate what we now know more than we need new knowledge, also seems perfectly clear. That this volume has developed a coherent framework upon which this correla-

tion can be based, is not to be denied. It will be interesting to see if anything comes of it.

Dr. Angyal is to be particularly congratulated for the clarity and restraint of his presentation. The book gains enormously from his ability to refrain from exploring the inviting side paths that open on almost every page. Unless you are one of those who must hurry through your reading, you will not mistake the meaning or miss the argument. And sometimes, as here, the publishers do such a grand job that one is tempted to forget how much faultless technique means in the conveying of a message.

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THE FIELD OF SOCIAL WORK. By Arthur E. Fink. New York: Henry Holt and Company, 1942. 518 p.

The purpose of the author in writing this book was to "present the subject of social work philosophy and practice in understandable, non-technical language." With the interests and needs of four groups of readers in mind—the student who is considering social work as a possible career, the beginning worker who is seeking knowledge and perspective on the larger area of social work, the layman who wonders why he should support social work, and the board member who is interested in a particular branch of social work and its relation to other welfare programs—the author has produced an excellent book which will prove equally useful for a variety of other purposes.

After an introductory historical chapter on the development of social work, three major social-work processes are examined—case-work, group work, and community organization, with chief emphasis on the case-work group. Under this latter heading are chapters on family-welfare work, child-welfare services, the child-guidance clinic, visiting-teacher work, the court, probation and parole, medical social work, and public welfare and public assistance. The two concluding chapters treat of social group work and community organization.

Impossible as it may seem to survey a field of social work in a single chapter, the author has succeeded in surmounting the difficulties exceedingly well. In his own words, each chapter "begins with a short historical account of the development of the work, proceeds to an analysis of philosophy and practice, and concludes with a discussion of job requirements, professional associations and training, and trends." Each chapter is followed by a concrete illustration, a case history contributed by an active practitioner in the particular field covered. At the end of the book is a comprehensive bibliography of books, pamphlets, and articles which encourages further reading on the subject content covered by each chapter.

It is difficult to analyze just why the frequently used phrases, "social work is a helping profession," "a person who is in a helping rôle," "comes offering a helping service," "to know what kind of and how much help to offer," "to give him such help as he is able to take," and "a helping person," seem to set up a slight degree of irritation and resistance. Somehow these phrases do seem to carry a connotation of smugness, complacency, and omniscience which the users, in reality, may be entirely guiltless of feeling. It appears, however, that the social workers of Philadelphia represent a group highly susceptible to ideational and verbal contagion, and one is immediately able to recognize those students who have been exposed to this penetrating influence by their constant use of the phrases currently in vogue in that center. The author is obviously one who has recently been engaged in absorbing Philadelphia concepts and this is particularly evident in his chapter on the child-guidance clinic.

In this chapter, the philosophy, methods, and values of the Philadelphia Child Guidance Clinic are presented in such detail that the uninitiated would gather that they are more or less typical of all child-guidance clinics, or the goal toward which all should strive. As an example of a child-guidance clinic in a community with many and varied social and psychiatric resources, which has concentrated on the area of parent-child relationships within a certain limited framework of thinking, the description is very well done. The majority of clinics, however, do not and cannot limit their approach and clientele in this way, but have to adjust their services and methods more flexibly to the situation presented in each individual case. There are a variety of other factors besides parent-child relationships that may contribute to maladjustment in children, and these, too, should "be helped," if possible, by "what goes on in the clinic."

There is also something a little reminiscent of the old, frequently noted entry: "Case closed. Client refused to coöperate," in placing the entire responsibility for success or failure on the client's "capacity to take and make use of what the clinic has to offer." It might be of value to penetrate a little further into these matters, critically evaluating "what the clinic has to offer," as well as the underlying causes that prevent the client from taking and making use of the clinic's proffered services.

The reviewer has already found this book of great use in orienting students who have developed a somewhat vague interest in social work, who are debating whether or not to seek professional training in the field, or who desire an over-all perspective on social work as an aid to broader functioning in their own professional field.

CLARA BASSETT.

University of Texas School of Medicine, Galveston.

TRAINING FOR SKILL IN SOCIAL CASE-WORK. Edited by Virginia P. Robinson. (Social Work Process Series, Pennsylvania School of Social Work.) Philadelphia: University of Pennsylvania Press, 1942. 126 p.

This volume presents the philosophy and the method of education expounded and practiced in the Pennsylvania School of Social Work. In the introduction, the editor states that although there is an abundance of curriculum content from the field of social work and related fields which must be built into the student's program, this volume will not attempt to discuss any elements of the curriculum beyond the practice unit—that is, the two-year curriculum in social case-work.

The first five papers, from members of the case-work faculty and two field-work supervisors, describe three elements of the practice unit—classroom content in case-work, personality, and practice in a social agency—and endeavor to show how these parts are interrelated through a "pattern of training." Two other articles—*The Relation of Function to Process in Social Case Work,* by Jessie Taft, and *The Agency's Rôle in Service,* by Kenneth L. M. Pray—also are included, to clarify the three concepts, "function," "process," and "the service agency," which are essential to an understanding of skill as defined and described in the preceding papers.

This work impresses the reviewer as being unique in two respects: first, in that the faculty contributors speak as one, from the standpoint of a philosophy and a method rather than from divergent points of view; second, in that the educational emphasis is on imparting *a* philosophy and developing *a* skill rather than on curriculum content. It is clear that this group of educators has shared the concern of their colleagues—concern that professional education in the field of social work shall prepare the student for skilled practice. It has long been realized that this entails something more than the conveying of knowledge. A growing awareness of the importance of emotion in the educative process has brought realization of the limited value of a superstructure of knowledge. The goal of enabling the student to assimilate, rather than merely to annex, content is not peculiar to this group or to educators in this profession. Concern over this problem may be more pronounced in the group represented here, and one notes in these papers a prolonged absorption in dealing with it. Their ways of solving the problem are in many respects peculiarly their own. Professional education in the field of social work is indebted to the faculty of this school for having shared their experimental efforts with us. Whether their work contributes in part or in whole to educational methods practiced elsewhere, or whether, instead, it stimulates thinking so that others become more analytical and more

prone to experiment and to formulate differing philosophies and methods, it will serve an invaluable purpose.

The concepts of the place and the function of social work, as well as the educational emphasis, presented in this book represent a radical departure from traditional as well as current thinking and practice. It probably will elicit many expressions of dissent, and this reviewer is prompted to comment on a few of what seem to her to be outstanding points of divergence.

The editor states that social work can no longer carry the burden of social reform. She adds, "I believe that this recognition of the contribution of social work can only be established if the profession of social work can separate itself from its identification with the social conscience and social reform and find a rôle for itself in a more limited and more effective relation to social problems." The reviewer agrees that social work cannot carry alone the burden of social reform, but believes that it must everlastingly share that burden in ways both of support and of leadership. It is her conviction that social work will cease to be social work when it breaks off or denies its identification with social reform and social conscience, but that does not mean that it should not understand and objectify this identification.

In so far as the social agency has been futile in its social-reform efforts and in its rôle as "the conscience of the community," important factors in that futility have been its lack of intelligence as based on knowledge, and its inability to utilize its intelligence because of its subjective involvement in the issues at stake. Specifically, the social worker became stigmatized as an ineffectual and absurd social reformer in so far as his own needs made it necessary for him to attempt to impose himself on others—that is, to re-create the individual in his own wishful image of himself or to mold the world to his own liking without realistic reference to the wishes and needs of the individuals and groups concerned. Effective social reformers probably always have been intuitively aware of psychological readiness for change and have been past masters at affirming the dynamic wills of individuals and groups, enabling the impulse to change to find concrete expression as it has been offered a vital relationship with leaders. One wonders, therefore, whether social work is confronted with the question of social reform versus "finding a rôle for itself in a more limited and more effective relation to social problems," or whether it is struggling to understand itself in relation to the social conscience—that is, striving to make its part in social reform a conscious process rather than merely an intuitive or a haphazard one.

While the editor of the volume comments that skill rests on knowledge, and at several points mentions that certain contents are essential, it would seem that there is what many might consider an over-

emphasis on attainment of skill and a minimizing of the importance of knowledge. The focus of the volume, however, may give an erroneous impression in this regard, and therefore, with some reservations stemming from a fear of having misinterpreted the writers, the reviewer takes issue with what appears to be a tendency to place skill first and foremost, and to isolate it as something that can be taught, if not apart from, at least in advance of, the acquisition of knowledge. It would seem that knowledge and skill should go hand in hand, and while we know that knowledge may exceed skill, it is not clear that skill can greatly surpass the student's intellectual orientation.

One important factor among others here is that anxiety and confusion arise to interfere with skill when the student must deal with situations that confront him with his ignorance. Perhaps some of us will be more ready to give the emphasis on curriculum content second place when it has attained a greater degree of adequacy. Any ineffectualness of social work as a profession has so obviously stemmed in large measure from the meagre knowledge of its members that one hesitates to minimize the importance of curriculum content at this point in history.

One outstanding example of this is the picture that the editor gives in this statement: "As unemployment increased in the late twenties, the inadequacy of the resources of the private agencies to handle the need it created, forced upon the field and the Schools the recognition of another area of content and a requirement for definition of new tasks and for the development of new skills." How well we know to-day the dilemna created by this unreadiness—a lack of preparation that stemmed at least in part from a lack of knowledge of the *import* of the fact that unemployment long had been waxing and that public-welfare expenditures long had been mounting.

In these papers one notes also the emphasis placed on "training pattern," on unanimity of point of view, on concentrated effort to integrate the elements of the student's experience. In solving the difficult problem of enabling the student to assimilate, rather than merely to annex, contents, we have been aware of the danger of going too far in giving him a predigested experience. It is the conviction of some educators that graduate professional students may well be exposed to conflicting points of view, may well experience different patterns of training, and may well struggle to reconcile these differences. Their assumption would be that in this struggle lies growth. If students are spared this conflict and experience only the "relatedness" that one unanimous group have found as a result of this struggle, then there is a danger not only that they may not go beyond their predecessors, but that they may serve only as pale substitutes for them.

The reviewer raises these questions with some reservation, determined by the focus of this volume, and with the wish that this consideration of "skill" might have been given to a greater extent within the context of the content. One looks forward with interest to subsequent presentations which may discuss the curriculum as a whole.

CHARLOTTE TOWLE.

The University of Chicago.

PSYCHIATRIC NURSING. By Katherine McLean Steele. Philadelphia: F. A. Davis Company, 1941. 390 p.

Mrs. Steele is in position to speak with authority about mental nursing, having been responsible for directing it in such hospitals as Phipps Clinic, Colorado Psychopathic Hospital, Worcester State Hospital, and an institution in Venezuela. She has written this textbook for students of nursing in general hospitals who are taking an affiliate course in a mental hospital. Such students usually have their affiliate experience in the intermediate or the senior year. Hence they already have had their courses in basic sciences and nursing arts, and their experience in general nursing, in care of both medical and surgical cases, in diet therapy, and in several other assignments, including night duty. The author assumes such basic preparation, and while she recommends a review of neuroanatomy, physiology, psychology, and related subjects just before the psychiatric experience is undertaken, wisely she does not burden this volume with those subjects; she neither underestimates previous experience nor expects too much of it. The book, therefore, should meet the needs of the average student.

The book is arranged in five units and an appendix. Unit I is designed to orient the student in psychiatry. It is a good presentation of the need for emotional adjustment, and it is planned to help the student overcome the fears so frequently present on beginning work in the mental ward. One could wish that the psychology presented were of a somewhat more dynamic type, but it is perhaps better to avoid the chance of confusing a student who has only three or four months for this course by offering her too wide a range of theory regarding human motivation.

Unit II, devoted to practical procedure in psychiatric nursing, covers care of the patient at home, in the general hospital, and in the psychiatric hospital, with discussion of many nursing procedures.

Unit III describes the types of mental ailment by diagnosis. A section of ten pages devoted to hypoglycemic shock treatment is credited to Dr. D. Ewen Cameron.

Unit IV discusses the legal aspects of nursing, including various items that nurses should know for the protection of their patients and

for their own information. The laws cited are well chosen. A chapter on psychiatry and public health is credited to W. Wallace Weaver, of the University of Pennsylvania.

Unit V presents the historical background of the present-day mental-hygiene movement. The appendix includes a glossary of terms used in psychiatry, a bibliography, and a state-board examination in psychiatry.

Quotations are frequent, and extensive use is made of illustrative material such as statements by patients, abstracts of books, case studies presented by students, and material taken from various authoritative sources. Suitable acknowledgments are made in the text, but the names of the authorities cited are not included in the index, which is evidently designed for the immediate needs of the student and is indeed very practical. There are numerous pictures and the press work on the book is excellent.

MARY E. CORCORAN.

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INTRODUCTION TO SOCIAL PSYCHOLOGY. By Maurice H. Krout. New York: Harper and Brothers, 1942. 823 p.

This book is essentially a compendium of research results on a number of conveniently grouped topics. It is not in any sense a treatise. It is not original either in conception or in content. It has no special point of view, except that, where possible, the author emphasizes the environmentalist as against the hereditarian bias, and the culturistic as against the organic.

The material is grouped under eleven chapter headings: *Environment; Heredity; The Organism; The Group; Culture; Patterning; Survivals; Change; Conflict; Leadership;* and *Followership.* One may guess from these headings that the general orientation is that of the sociologist rather than that of the psychologist. One misses headings that are usually found in texts on this subject, but one will find them all treated in the body of the work in suitable places. A vast amount of work has gone into the reading and digesting of hundreds of individual researches on the above topics. These digests are, for the most part, interesting and accurate, and it is they that make the work valuable as a reference book. The author exposes some glaring defects in his efforts to play up his own predilections, but these are compensated for by the encyclopedic character of the research summaries, the numerous excellent charts, tables, and pictures, and the exhaustive bibliographies, covering 56 pages.

This is not, however, a weighty work, even though it weighs nearly three pounds. Controversial matters are nowhere clarified by dis-

criminating analysis; researches are included often with little regard for their relative merits; and all too frequently a mass of research summaries are left as a jumble of contradictions, with no interpretative analysis or logical integration.

The author claims in his preface to present in the first chapter "a definite point of view on the very special part which the physical world in any form may be said to play in human conduct." The reviewer fails to discover this point of view. The conclusion would seem to be that climate and topography do have some effects, but what they are is somewhat unclear, so that the whole subject needs further investigation.

The next two chapters deal with the heredity-environment problem and are by all odds the weakest of the book. The author exhibits both ignorance and deep-seated bias. In his explanation of Mendelism, he replaces Mendel's three laws by four "principles," and defines these in original and startling ways. The principle of segregation "states that we inherit a number of characteristics as units . . . transmitted as wholes." The principle of recombination "states that the genes are shuffled about in the chromosomes and dealt out in various combinations in chance order." Because of the principle of independent assortment, "the traits that are finally assorted in the offspring not only are possible in all combinations, but are independent of the parent stocks." It is almost unbelievable that any one to-day could hold such fantastic notions as to what the modern theory of heredity is. Other statements of like error and obscurity are found in this section. The author concludes that mutations throw out most of Mendelism; and that "genes can tell us what will not happen rather than what may."

Something of the same fuzzy obscuration and devious twisting of facts and ideas carries over into the next chapter, which deals with the causes of feeblemindedness and the structural basis of behavior. There is some naïveté, some bold rejection of what nobody now claims, some deceit of language, and some mere innuendo. When the author concludes that the I. Q. "is not innate," he does not mean that it has no organic or hereditary basis, but that it is not as high at birth as it is later. This manner of speech is not that of the true scientist. The author relies heavily on Boas's classical study, which was rejected by the expert statisticians of the Galton Laboratory.

These criticisms indicate the weaknesses of this work. It is questionable whether it is sound enough to warrant its use for its intended purpose. It should prove valuable, however, to discriminating readers and advanced students as a work of ready reference.

FRANK H. HANKINS.

Smith College, Northampton, Massachusetts.

SUN CHIEF: THE AUTOBIOGRAPHY OF A HOPI INDIAN. Edited by Leo W. Simmons. New Haven: Yale University Press, 1942. 460 p.

This autobiography of a Hopi Indian, Don C. Talayesva, is a fascinating human document, which the scholar will read with profit and the intelligent layman with pleasure. It is a veritable storehouse of types of information that seldom find their way into standard monographs.

In an introductory chapter, Dr. Simmons sets forth the objectives of the book: (1) the need for a comprehensive life history, (2) written chronologically, and placed in its social and cultural setting, (3) to permit of a systematic analysis of this particular set of human experiences, (4) for the purpose of obtaining data for generalizations. It is to be hoped that Dr. Simmons will devote another book to the systematic analysis of these data in terms of objectives (3) and (4). The chapters entitled *Concerning the Analysis of Life Histories* and *An Example of Situational Analysis* suggest that he is capable of the highest type of constructive analysis. He studies individual behavior in terms of a conceptual scheme that views behavior as the result of man's quadruple function as a (1) creature, (2) creator, (3) carrier, and (4) manipulator of culture.

Dr. Simmons' greatest contribution seems to be his consistent policy of viewing man's active life as a systematic manipulation of culture. Thus it would seem that the manipulation of culture is actually a super-category, and that man's behavior as a creator, creature, and carrier of culture is by and large an epiphenomenon of his behavior as a manipulator of culture.

Talayesva is undoubtedly a neurotic, although Dr. Simmons nowhere labels him explicitly as such. The question arises: Is this neurosis due to a clash of cultures and to the difficulties of a dual adjustment, or is it primarily due to the structure of Hopi society? Dr. Simmons' interpretative chapters emphasize the culture-conflict aspect of the problem. The reviewer, on the other hand, feels inclined to emphasize the structure of Hopi society as a causative agent, without thereby denying the importance of the culture conflict. To this reviewer, Talayesva's "White period" at school and at Riverside Institute was—so far as "meaning" is concerned—mainly water off the duck's back. White cultural devices never rose for Talayesva above the level of "tools" and never turned into "meaning."

Hopi social life is highly traumatic to the individual. This autobiography explodes—unwittingly and by implication—the sweetness-and-light interpretations of Pueblo life that have gained some currency, and shows the Hopi as they are—the "*petits bourgeois* of the

Southwest," as Professor Lowie calls them. Under a thin veneer of loving-kindness, there seethes a witches' cauldron of hate, gossip, and fear of witchcraft. Aggression is barely held in check by promiscuousness. The Hopi are one of the very few peoples who openly express their resentment of the dead, slapping them and accusing them of having died simply to aggrieve the survivors. Certain groups among ourselves will be pleased to learn that the Hopi call improper behavior simply "un-Hopi" *(kahopi)*. The gods must laugh!

No brief review can even begin to give an account of the wealth of psychiatrically relevant material. Talayesva's castration anxiety is, however, worthy of special notice. Because of an early castration threat Talayesva is unable to castrate his live stock, although he can kill them (having himself nearly died once), brand them (having himself been badly burned), and whip them (having been flogged very severely during his initiation). Yet he courts "castration" all his life through aggressive and promiscuous behavior. His statement that in early childhood he came to look upon his penis as the most important part of himself is interesting, particularly when correlated with his lifelong, and almost paranoid, fear of witchcraft, culminating in temporary impotency with his wife (whom he shortly afterwards overtly likens to his mother). Talayesva's life is an unusually clear-cut manifestation of the "aggression-dependency" complex defined by Horney.

A somewhat more complete index would have been helpful.

To sum up, *Sun Chief* is likely to become an anthropological classic, and what is more, an interesting classic.

GEORGE DEVEREUX.

University of Wyoming, Laramie.

SELF-ANALYSIS. By Karen Horney, M. D. New York: W. W. Norton and Company, 1942. 309 p.

In attempting to talk to the lay public about the question of "self-analysis," Dr. Horney has deliberately left herself open to attack by her former analytic colleagues. The accepted and tested method in all science is to present a new problem, or a new departure from currently held views, to those who know the field and who are in a position to detect the possible errors in the new approach. If, as sometimes happens, the experts have become too conservative and hidebound to give an honest and understanding appraisal of the new approach, then, of course, it is necessary to find a new and unprejudiced public. And such becomes the plea of every peddler of nostrums. It is clear to the reviewer that Dr. Horney believes this situation to have arisen in the field of psychoanalysis, and equally clear to him that her belief is based, in part at least, on something

that she has overlooked—her own misrepresentations of Freud's theoretical position.

Her main thesis may be put this way: There is a constructive impulse or principle in the individual, a something that might be called a special self-creative impulse, or, if not that, at least something that looks like that and is believed to be that by many people for whom the evidence lies all around. The existence of such a principle she feels that Freud quite explicitly denied, and that is the way the reviewer would understand Freud also. From the fact of Freud's denial, she would seem to infer that there is then no place for such a principle within the Freudian theoretical system, since, of course—so runs the tacit conclusion—if there were, Freud himself would have seen it. This seems to the reviewer a *non sequitur* of the first water. Neither Freud himself nor any of his sincere followers have ever claimed for him that he had exhausted the possibilities of his theory. It was only a beginning, not a finished product.

To support her thesis, Dr. Horney has tucked away on page 269 a version of the Freudian life-death-instinct theory that is a complete misrepresentation: "If man is driven by instincts and if among them a destruction instinct plays a prominent part—as was the contention of Freud—not much, if any, space is left in human nature for constructive forces that might strive toward growth and development." To the reviewer this is the same as saying: Freud asserted that there are both a constructive and a destructive principle; therefore, he asserted there is no constructive principle or only a weak and ineffective one. When Freud redefined "libido" as "eros," he defined it as a constructive force that leads to growth and development. And he asserted likewise that there is no need to postulate any other such force. Now one does not have to be a psychoanalyst to perceive the logical fallacy into which Horney has fallen. Freud did not say: There is nothing but a constructive instinct, or else nothing but a destructive instinct. He did say that there are both and that every phenomenon of life and death is the resultant of the interplay of these two forces.

Horney's departure from the Freudian theory continues. She gives up the whole theory of a dynamic conflict among instincts as reflected in the tripartite structure of the psyche. In place of this she substitutes a conflict among vague somethings she calls "neurotic trends," which are compulsive in their effect—*i.e.*, are really neurotic symptoms. Perhaps she is right in believing them not to have been adequately described hitherto, although Rank, for one, wrote several books about the ones she describes. But in any case her new theory, which she would substitute for the Freudian, amounts to this: Neurotics are neurotic because they have neurotic symptoms.

Somehow, by an introspective taking stock of themselves and recognizing that they are neurotic, neurotics are to achieve a cure or betterment of their condition. By such a process neurotics can make their compulsions less compulsive. The fact that this kind of effective introspection occurs, if ever, only under certain undescribed super-ego formations, is a problem in Freudian theory that Horney has not stopped to consider.

The reviewer is rather surprised that one of the strongest arguments for the possibility of a profitable self-analysis is one not employed and developed by Horney. That is the fact that the very existence of self-analysis itself in its present form was the consequence of Freud's own self-analysis. And what has history to say about the state of affairs that held with Freud's earliest followers?

On the positive side, it may be said that the book is devoted to a very good account of how one would go about carrying on a self-analysis and of the adventures one would encounter in the process. This discussion gives a very clear and probably useful picture of the conflict of motives within the psyche, and the very superficiality of specification as to their nature is, one would suppose, especially designed to be effective for the layman. For such individuals, the usual Freudian vocabulary has become a bit trite and uninformative because of its use in name-calling.

Sandwiched in between discussions of the general feasibility and desirability of self-analysis and of the forces at work favoring and limiting it are some interesting illustrative cases—single instances that establish the existence of the behavior in question and a fairly long account of the use made of self-analysis by a girl named Clare. Clare had started an analysis with Horney and broke it off. Eventually she returned to Horney to finish her analysis. In the interim she successfully carried through a "self-analysis" that freed her from a dependence on a particular male and on males in general. That this dependence was a defense against her relationship to women, a defense that had to be solved by a return to a woman analyst to fight it out, is indicated, but not analyzed.

In spite of her untenable theoretical position, Horney has produced a book that the reviewer has no hesitancy in recommending to psychoanalysts. They will find it interesting reading; besides which it will pose some problems for them to answer. For the lay public it is to be feared that the book will be only an interesting, but misleading nostrum. Possibly the more modern type of characterology offered will be of advantage in contrast with the handbooks of the past.

GEORGE B. WILBUR.

South Dennis, Massachusetts.

INTRODUCTION TO THE PSYCHOANALYTIC THEORY OF THE LIBIDO. By Richard Sterba, M.D. New York: Nervous and Mental Disease Monographs, 1942. 81 p.

In the preface to this book, the author expresses his concern over the neglect of the libido theory on the part of a group of psychoanalysts. "For these instinctual forces they substitute cultural influences in order to explain neuroses, and they regard themselves as being advanced in comparison with Freud and his theory of instincts. . . . It seems timely, therefore, to recapitulate Freud's findings in the domain of the instincts and particularly of the sexual instincts."

Under the following chapter headings, the author then presents the "classical" Freudian theory of the libido, supplemented by the contributions of Abraham: I. *The Instincts;* II. *On Human Sexuality;* III. *Description and History of the Development of Child Sexuality,* comprising (a) the first oral phase, (b) the second oral phase, (c) the first anal phase, (d) the second anal phase, (e) sadism and masochism, (f) the genital phase, (g) the latency period and puberty; IV *Narcissism;* V. *The Vicissitudes of the Instincts;* and VI. *Repetition Compulsion and Death Instinct.*

In general the author presents his material simply and clearly, interspersing a considerable body of the observational data on which the theory is based. The principal advantage of this particular presentation is that it brings together in one place material that is more or less scattered through the literature. Automatically, however, this brings with it the disadvantage that much of the historical and clinical perspective must be omitted.

The task of presenting the libido theory is an exceedingly difficult one because of the extremely unconventional character of the facts and observations that the theory attempts to explain. Cultured persons have been trained from earliest childhood to forget or to ignore events of the type under discussion. To be understood in their relationship to personality, they should be described in their natural setting along with those other forces and functions that try so desperately to keep them hidden, inactive, or disguised. Their isolation may tend to confuse rather than to enlighten the "non-analytic" reader.

E. VAN NORMAN EMERY.

Washington University, St. Louis, Missouri.

THE 1941 YEAR BOOK OF NEUROLOGY, PSYCHIATRY, AND ENDOCRINOLOGY. Edited by Hans H. Reese, M.D., Nolan D. C. Lewis, M.D., and Elmer L. Sevringhaus, M.D. Chicago: The Year Book Publishers, 1942. 768 p.

This volume follows the usual pattern of the series in which it appears. In the many years during which the reviewer has been

acquainted with these yearbooks, there has been considerable improvement in them. The present editors have done about as well as could be expected in a work of this kind.

The principal difficulty with all such works is that inevitably they are never quite complete, sometimes omitting what may be important contributions in one or another field. In former volumes the abstracts themselves have at times not been entirely accurate, although that criticism does not seem to apply to the one under review.

To one who has access to a fair library of current psychiatric books and journals, these yearbooks are of little use. At best they serve for quick reference in the investigation of the background of some special problem, if indeed one is fortunate enough to find it mentioned in them. Even this service is more quickly and comprehensively secured from the *Quarterly Index Medicus* and the journals. Moreover, where obscure points are concerned, one does much better to read the original article, however competent the abstracter may be. The year book will probably find its greatest field of usefulness in situations where psychiatrists are remote from good medical-library facilities.

LAWRENCE F. WOOLLEY.
The Sheppard and Enoch Pratt Hospital, Towson, Maryland.

CONCEPTUAL THINKING IN SCHIZOPHRENIA. By Eugenia Hanfmann and Jacob Kasanin, M.D. New York: Nervous and Mental Disease Publishing Company, 1942. 115 p.

In this monograph Kasanin and Hanfmann have collected their experiences with the Vigotsky test in the attempt to bring some definition, by experimental means, into the problem of the thinking disorders of schizophrenia.

They formulated the following questions:

> "1. What variations of performance occur in the concept formation tests and in which way can they be construed to indicate different levels of thinking?
>
> "2. To what degree is the performance in this test dependent on the educational level of the subject?
>
> "3. Do schizophrenic patients actually show a reduction of conceptual thinking as compared with healthy persons of the same educational level?
>
> "4. If such reduction of conceptual thinking exists, is it found in all patients as Vigotsky seems to imply, or is it limited to certain clinical groups? Do different groups of patients manifest different degrees of disturbance?
>
> "5. Is the disturbance found in schizophrenic patients comparable in character and degree to that manifested by patients with organic brain disease?"

This ingenious test, first devised by Ach, is designed to show those qualitative levels in thinking that have been variously referred to as adult-logical-abstract-conceptual, and primitive-childlike-archaic-concrete.

The test showed roughly that the thinking processes varied between these poles, and was best in the college educated; that schizophrenics as a class did less well than healthy adults, but better than paretics and arteriosclerotics; and that various kinds of schizophrenics gave a varied performance on the test, some justifying Kasanin's view that there is a type with "primary thinking disorder" as the principal difficulty.

The authors evolved a point scale for grading the performance, through which the observations could be reduced to easily understood terms.

There are several important points to note about the findings:

A shift from conceptual thinking to more concrete thinking often occurred under the stress of emotional frustration, which presupposes a certain grasp of the situation. Yet the authors deny Cameron's insistence on the emotional basis for the characteristic thinking disorders he discovered by use of the same and other tests. To the reviewer—who did not sit in on either set of experiments, but who has had acquaintance with many schizophrenics—it appears that accurate judgment on the emotional state of these subjects might be well-nigh impossible, certainly if based exclusively on their verbal comments. Can the authors assert that emotional factors have been excluded simply because those patients who showed the ordinary emotional expression were eliminated?

The authors suggest that the performance of schizophrenics is qualitatively in many respects not unlike that of paretics and arteriosclerotics ("irreversible" cases), and this observation warrants the suggestion that deterioration in the thinking processes may proceed along a final common pathway, even when initiated by diverse factors.

The authors mention the reviewer's clinical observations (among others) relative to the schizophrenic's misuse of metaphors. They omit the really pertinent item from this contribution: that such misuse is *spontaneous,* and always related *directly* in an *emotional* way to the dynamic factors in the illness. This was noted in the complete absence of similar distortions in the experimental situations of explaining metaphor, proverbs, and so forth. The reviewer finds it somewhat difficult to believe that an "impersonal" disease such as paresis or arteriosclerosis—if any disease is really impersonal—could bring about disturbance along such "lines of cleavage" of the personality. My view would fit in with certain of the authors' findings and with Cameron's—that the thinking disorder proceeds under the

impetus of transitive emotions. Furthermore, I would not hold the view that experimental situations, in contrast to clinical observation, necessarily connote "*more* controlled observations."

This is a good book, full of interesting detail, and providing a most helpful index to the use and interpretation of the Vigotsky test. The literature is covered in a welcome fashion.

WENDELL MUNCIE.

Baltimore, Maryland.

BUILDING MORALE. By Jay B. Nash. New York: A. S. Barnes and Company, 1942. 154 p.

Dr. Nash outlines some of the factors in training that are necessary to establish "unity of purpose" in a nation, whether at peace or at war. The approach is individualistic in that it is based upon the conviction that through proper educative procedures, with adequate consideration given to the physical, intellectual, and spiritual needs and potentialities of each child, a generation of men and women can be raised who will have a proper respect for and pride in our nation. Such a society stands out in happy contrast to the totalitarian state. In such a training program as that outlined by Dr. Nash, due emphasis is placed upon the past accomplishments of this nation and also upon the ills of our society that must be eliminated if individual and group morale is to be maintained at its highest and most useful level.

GEORGE E. GARDNER.

Judge Baker Guidance Center, Boston.

NOTES AND COMMENTS

Compiled by

KATHARINE G. ECOB
New York State Committee on Mental Hygiene of the State Charities Aid Association

WAR MAN-POWER COMMISSION

Policy on Employment of Youth Under Eighteen Years of Age

The document quoted below was recently issued by the War Man-Power Commission as a statement of national policy in the matter of safeguarding the health, welfare, and education of American youth under eighteen years of age whose services are being demanded by the war program.

"The necessary expansion of our military industrial personnel requires maximum utilization of all available and potential sources of labor. These potential sources include youth between the ages of fourteen and eighteen years whose services would not be immediately required in normal times. If employed, however, it should be only under conditions which adequately safeguard their physical and intellectual development.

"The first responsibility and obligation of youth under eighteen even in war time is to take full advantage of their educational opportunities in order to prepare themselves for war and post-war services and for the duties of citizenship. It is essential that young people have the fullest possible opportunity consistent with the war effort to complete their education. Those with special aptitudes and capacity for further training should continue their education in order to develop their maximum abilities applicable to war and post-war needs.

"In most cases youth under eighteen can best contribute to the war program by continuing in school and, when their services are required, accepting vacation and part-time employment. However, it is recognized that the demands of the war period will increase the number who in normal times leave school to enter full-time employment before reaching eighteen. In any case, all forms of employment of such youth, including employment in agriculture, must be specially safeguarded. Their services must be used in such ways as to bring about their maximum contribution to man-power needs consistent with the protection of their health and welfare and the fullest utilization and development of their aptitudes, abilities, and interests. The achievement of those objectives requires the active coöperation of young people, their parents, government agencies, educational authorities, management, and labor.

"To promote proper utilization of the labor resources of youth with due regard to the welfare of youth and the future needs of the nation,

the War Manpower Commission hereby declares as basic national policy that:

"1. School attendance laws and child-labor standards embodied in state and Federal laws be preserved and enforced, and the minimum standards hereinafter listed not be construed to warrant any relaxation of these laws or lowering of the standards embodied in them;

"2. No one under fourteen years of age be employed full time or part time as a part of the hired labor force;

"3. Youth under eighteen years of age be employed only:

"a. after the employer obtains proof of age in the form of employment or age certificates or, in case such certificates are not legally required, other reliable evidence;

"b. in work suited to their age and strength, avoiding all occupations that are hazardous or detrimental to health or welfare;

"c. where provision is made for adequate meal and rest periods or time, and facilities therefor, adequate sanitary facilities, and safeguards for health and safety;

"d. for periods suited to their age and strength, and in no case for more than eight hours a day or six consecutive days, except as deviations may be necessary where the worker is engaged in continuing farm work of a non-seasonal character and is domiciled at the place of employment, or except as temporary departures from the above standard under adequate safeguards, where permitted for youth aged sixteen and seventeen under existing Federal or state laws, rules, or regulations, may be necessary to meet a special emergency;

"e. during hours of day not detrimental to their health and welfare; and

"f. at wages paid adult workers for similar job performance;

"4. Youth aged fourteen or fifteen be employed only when, in addition to the foregoing conditions:

"a. qualified older workers are not available; and

"b. the employment is not in manufacturing or mining occupations;

"5. In-school youth be employed only to the extent that the combined school and work activities involve no undue strain, and that combined school and work hours, at least for youth under sixteen, not exceed eight a day;

"6. In-school youth not be employed during school hours unless the area or regional man-power director has determined that temporary needs of an emergency character cannot be met by full use of other available sources of labor, in which case school programs shall be adjusted under plans that:

"a. provide for the educational progress of those who take employment;

"b. avoid interference with the school attendance of those who do not take employment; and

"c. avoid the closing of any school or grades therein, except to the extent that the hours, terms, or curricula are readjusted to preclude the curtailment of educational opportunities;

"7. When war-time emergency coöperative arrangements have been entered into with school authorities for the part-time employment of in-school youth as a part of the school program, the employer be responsible for certifying to the school authorities that such employment will be in conformity with state and Federal laws governing the employment of minors and with the standards contained in Sections 3 to 7 above, and the school authorities be responsible for permitting school children to take only those jobs that will contribute definitely to their educational welfare and useful work experience;

"8. When it is necessary to transport young people to and from work, safe and adequate means of transportation be provided, and the period of work and transportation not exceed ten hours a day;

"9. Where youth under eighteen years of age are recruited in groups for agricultural work requiring them to live away from home, prior to placement, assurances be furnished by appropriate community or other agencies that suitable living conditions, sanitary facilities, health protection, supervision, and leisure-time activities will be provided; and in no case youth aged fourteen or fifteen be recruited for work requiring them to live away from home except where such work is in connection with programs conducted by recognized youth-serving agencies that provide close supervision;

"10. Any youth interested in work in another area not leave his own area in search of work without first:

"a. registering for employment at the nearest local office of the United States Employment Service or such other agency as may be designated by the War Manpower Commission;

"b. presenting evidence of parental consent; and

"c. being referred by such office to a specific job opening where he can be lawfully employed, and where there are suitable arrangements for housing."

Commenting on this policy, Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, pointed out that the type of work in which teen-age youth is employed is also an important consideration. "There has been," Dr. Stevenson states, "a wide difference of opinion among intelligent and sincere people regarding the employment of youth in their middle teens. On the one hand, work is seen as a stultifying element in the growth of the child from which he should be freed in a democracy. On the other hand, work is seen as a creative opportunity and an opportunity to enjoy advantages that would otherwise be denied and that actually contribute to the growth of the child.

"The first of these views refers to a form of work to which we are accustomed to apply the term drudgery; the second to a form of work that has training and educational advantages and that is not so distinct from education or even from play. This is a distinction that should be kept to the fore in any employment program for youth under eighteen years of age, and so far as possible the monotonous, unstimulating type of work should be kept at a minimum. The

mental health of youth in this situation will be further influenced by conditions of work and by a type of supervision that is sensitive to danger signals pointing to the need for individual attention."

The School of Military Neuropsychiatry

The authorization by the War Department of a School of Military Neuropsychiatry, located at the Lawson General Hospital, Atlanta, Georgia, marks a significant milestone in the history of American psychiatry.

It fulfills a need which has been recognized by both civilian and military authorities for a concentrated basic revaluation of neuropsychiatry in its utilization within the military setting.

The officers designated to attend the courses "will be carefully selected individuals who have had a minimum of twelve months' full-time training or practical experience in neurology or psychiatry or a combination of the two."

The Lawson General Hospital, under the command of Brigadier General W. L. Sheep, is a 2,000-bed general military hospital, with a large neuropsychiatric service. It provides the type of clinical material and administrative problems peculiar to the military service, which are essential to the fulfillment of the mission of the school. Although the fundamental principles of civilian and military neuropsychiatry rest on the same broad basis, nevertheless, the actual problems faced by the medical officer are essentially different. To provide adequate indoctrination, it is essential that such a course be given in the setting of a military installation. The approach to the teaching problem is a flexible one, based on the practical clinical and administrative situations peculiar to the military neuropsychiatrist.

The previous neuropsychiatric training and interests and the amount and type of military experience of the student officers vary greatly. This requires a curriculum in which this variability is given consideration.

An additional advantage of the school, which has been demonstrated by the experience of the first two classes, is the opportunity for a large number of neuropsychiatrists, of diverse backgrounds and interests, to live and work together for a month and to discuss common problems among themselves. The contributions of the student officers to the school, and thus to the service, have not been insignificant.

The faculty consists of Colonel William C. Porter, Lieutenant Colonel M. R. Kaufman, Major Joseph Fetterman, and Major William H. Everts. It works in close coöperation with the Neuropsy-

chiatric Branch of Professional Services, in the office of the Surgeon General, of which Colonel Roy B. Halloran is chief.

WILLIAM C. PORTER.

Colonel, Medical Corps,
Assistant Commandant.

WAR-TIME LEGISLATION FOR MENTAL-HYGIENE INSTITUTIONS

Governor Dewey, in his first message to the legislature, stated the need for immediate action in the Department of Mental Hygiene. He said that the man-power shortage in institutions was very grave. As of the date he spoke, there were approximately 4,500 vacancies in institutions with a monthly increase of more than 300. He recommended that legislation be passed permitting the following action:

1. To allow employees in institutions to work, if they so desire, an additional four hours a day overtime at their regular rates of pay, including both cash and maintenance.
2. To provide salary increases for the lower-paid institutional employees.
3. To eliminate inequalities in the adjustments made for the expenses of employees for room and board.

SELECTIVE SERVICE AND SOCIAL AGENCIES

In the December, 1942, issue of Alabama Social Welfare, the State Department of Public Welfare tells what Alabama is doing about questions of dependency and the aid rendered to families of selectees.

Since November, 1940, when the program was started, 34,193 investigations of dependency have been made for the local draft boards. Although the reports have been factual, without recommendations, nevertheless they have been based on a complete study of the family.

Allied to these reports has been the assistance given to the families of the enlistees. Many of the wives have been in need while waiting for the allotments from the government. The various departments have stepped in and tided the families over these periods.

ANNUAL MEETING OF AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

(Reprinted, with permission, from "Mental Hygiene News," Published by New York State Department of Mental Hygiene)

War themes dominated the deliberations of the American Orthopsychiatric Association at its Twentieth Annual Meeting, held at the Hotel Pennsylvania in New York City on February 22–24, under the

presidency of Dr. Henry C. Schumacher. *Problems of a War-Time Society, Destructive and Constructive Psychologic Forces, the Modification of Pre-War Patterns, The Treatment of Aggression, The Psychology of Pre-Adolescent Children in War Time, The Military Scene and the Individual*—such were the suggestive titles of some of the general sessions and section meetings which featured the three-day conference and drew an attendance of some fifteen hundred psychiatrists, psychologists, sociologists, psychoanalysts, educators, social workers, and other specialists in the study of human behavior.

Several of the discussants saw in the forces at work in the individual and society, under the impact of the fiercest world conflict in history, a challenge to fruitful study by the psychologic and social sciences of the inner resources of the human personality that might be brought to bear on man's quest for a better life, to serve him constructively in dealing with his destructive insecurities, anxieties, and aggressions, and to enable him to attain more rational perspectives in which "men may judge their worth less by their material greatness than by the flowering of their inner talents, and by the beneficent effect of these on the entire social structure."

An intimation of changing values was contained in an address by G. Howland Shaw, Assistant Secretary of State, who observed that a great "reclassification of what is important and what is not important is now going on all over the United States," that men are becoming skeptical of the inevitability of progress and are discounting the values hitherto attached to mechanical and material progress in particular, and that "this war is affording us opportunities for fashioning a philosophy of life more solid and more satisfactory than any we have known for many years past."

What psychiatry may learn from, and contribute to, the current scene was the subject of a paper by Dr. Robert P. Kemble, of the Army Medical Corps, who discussed the rôle of the military psychiatrist and showed how his functions differed from those of the peace-time practitioner. The military psychiatrist, Dr. Kemble said, is first and foremost a soldier, and his primary function is to help his army win the war. Time and effort, therefore, become vitally important and affect all the normal procedures of the psychiatrist. On the other hand, the limitations of time that rule out lengthy and intricate forms of treatment encourage the military psychiatrist to experiment with more direct and more dynamic approaches, which may considerably enlarge his knowledge and effectiveness in the management of mental disorders in general.

Dr. Morton A. Seidenfeld, of the Adjutant General's Department, discussed the contributions of psychologists with reference to special training units that have been established in the army to fit recruits

handicapped by language difficulties due to their foreign origins, as well as by slow learning processes, for military service. Dr. Seidenfeld testified to the effectiveness of this program in providing the army with increased man power and affording to many citizens otherwise qualified the opportunity to serve in their country's armed forces.

Many other papers were presented and discussed, in which investigators reported the results of their researches on a variety of problems. Techniques of study and treatment of behavior disorders received special attention in a series of symposia dealing with such topics as collective psychotherapy and diagnostic group work, treatment through the media of drama and music and children's art work, a new approach to the use of the Rorschach test with young children, infant reactions to restraint, hostility patterns, prognosis in the management of the defective delinquent, and the reactions of children with fathers or brothers in the armed forces.

Dr. George H. Preston, Commissioner of Mental Hygiene in Maryland, was elected president of the association for the ensuing year.

Utica State Hospital Celebrates Its Centennial

On January 16, 1943, the Utica State Hospital, Utica, N. Y., completed one hundred years of honorable service. The celebration was sponsored by the Oneida County Mental Hygiene Committee and the Utica Council of Social Agencies, in coöperation with the Board of Visitors of the Utica State Hospital.

The morning's program was devoted to addresses and greetings. The School of Nursing had a demonstration from 9 to 10 A. M., and from 12 to 2 P. M., Marcy and Utica State Hospitals had exhibitions of occupational therapy.

At the afternoon session several addresses were given. Mr. Homer Folks, Secretary of the State Charities Aid Association and Chairman of the Temporary Commission on State Hospital Problems, stated that prevention is the "white hope" of reducing the volume and cost of mental disorders. The state with a $40,000,000 annual budget for mental-hygiene institutions is making "one of its worst financial errors" in not pushing a preventive program. He declared that many millions a year in construction and maintenance costs could be saved by such a program.

Speaking on "The Tyranny of the Past and Hope of the Future," Mr. Folks recommended methods to control mental disorders. He urged centering one attack on more thoroughgoing and effective treatment of the mentally ill in the hospitals with the extension of shock therapy, parole, and family care, and directing another attack to prevention by means of earlier discovery and treatment through clinics and health centers.

He believes that the time has come for the state to begin to make good in a big way in attaining a prevention objective set thirty years ago, but not yet realized because the state has thought itself unable to afford an effective system of diagnosis and treatment through clinics.

Mr. Folks recommended that the state hospitals be made more fully hospitals in fact as well as in name, and that searching psychiatric examination of patients should select more patients suitable for parole and family care. He declared that while more fully trained psychiatrists in the hospitals, new modes of treatment, and a better understanding of environmental factors in causation are important, prevention is a "white hope beside which all three put together are relatively unimportant."

Other interesting addresses were given by Dr. Samuel W. Hamilton, Medical Hospital Adviser, Division of Mental Hygiene, U. S. Public Health Service, on "Psychiatry's Contribution to Public Health"; by Miss Emily J. Hicks, R.N., Executive Secretary, N. Y. State Nurses' Association, on "Psychiatry's Contribution to Nursing"; by Miss Virginia Scullin, Chief Occupational Therapist, Pilgrim State Hospital, on "Psychiatry's Contribution to Occupational Therapy"; and by Miss Hester B. Crutcher, Director of Psychiatric Social Work, N. Y. State Department of Mental Hygiene on "Family Care."

A very interesting and informative pamphlet entitled, *A Century of Progress at Utica State Hospital, 1843–1943,* has been issued by the hospital. The concluding paragraph of the first chapter summarizes the scope of the booklet. "In reviewing a century of service to the mentally ill, it is interesting to note that the Utica State Hospital has had only seven superintendents, including the present incumbent. And the story of its continuous advance in scientific treatment properly falls into seven periods of varying length, during which the duties of this notable institution have been successfully administered by these men. For this reason it seems fitting to present this short history of New York's first state hospital as chapters in the lives of its seven medical superintendents." This pamphlet may be obtained for fifty cents by writing to the hospital.

Research in Mental Hospitals

The National Committee for Mental Hygiene has published its second study on research in mental hospitals.

This study, which was made by 400 investigators in 79 centers under private auspices, in general and mental hospitals, clinics, medical schools and universities, in 39 cities and towns, in 22 states

and the District of Columbia, describes the investigation of the causes and treatment of mental disorders and defects. It complements the first study made in 1938 of state-owned and tax-supported institutions.

Both surveys were made in coöperation with and through funds provided by the John and Mary D. Markle Foundation.

The Research Council on Problems of Alcohol

The Research Council on Problems of Alcohol will award $1,000 for outstanding research on alcoholism during 1943.

The following conditions are announced:

1. The basis for the award is the contribution of new knowledge in some branch of medicine, biology, or sociology important to the understanding or prevention or treatment of alcoholism.

2. Any scientist in the United States, Canada, or Latin-America is eligible for the award.

3. The research may have been begun prior to or during 1943 provided (a) that the major part of the work be carried on in 1943, (b) that it be developed to a point that significant conclusions may be drawn before the end of 1943, and (c) that no report of work has been announced or described by any scientific body nor has work been previously published.

4. A statement of intention to try for the award should be sent to the council. If a research project is developed later in 1943, a statement of intention may be sent to the council at a later date.

5. A report on the work and resulting conclusions must be submitted to the council on or before February 15, 1944. The council will provide an outline for use in the preparation of reports.

6. The award will be in cash and will be given to an individual scientist whose work is judged worthy of the award.

7. If the Committee of Award is not convinced of the outstanding merit of the research done during 1943, it may, at its discretion, postpone the award until another year or until such time as the work merits the award.

For further information write to the Director, The Research Council on Problems of Alcohol, Pondfield Road West, Bronxville, N. Y.

Standards of Child-Health Education and Social Welfare

The Children's Bureau (U. S. Department of Labor) has issued publication No. 287 entitled *Standards of Child Health Education and Social Welfare.* These standards are based on recommendations of the White House Conference on Children in a Democracy and the conclusions of discussion groups.

The subjects discussed cover a wide range, but two topics are of special interest:

1. Mental health.
2. State and community provision for mentally deficient children.

It is suggested that for the better protection of the mental health of children, the community should provide a constructive program for mental health. This program should include child guidance and parent education and should care for all mentally and physically handicapped children. It should be offered to parents, teachers, physicians, nurses, social workers, and all others who could profit by it.

The child-guidance clinic should be staffed with a psychiatrist, a psychologist, and social workers. It should be available to all community agencies.

Another standard to be established is provision for an adequate state-wide program for the care of mentally defective children. This program should include the location, segregation, training, education, and adjustment of all defective children in the community.

The carrying out of this program in any community will lessen many of the problems arising from present conditions.

A Forward Step

An unusual and original step forward was taken by the Pine Tree (Maine) Society for Crippled Children. At a meeting held late in 1942, it was voted to include crippled children with mental handicaps in the teaching program of the society. It is very rarely that mentally defective children with physical handicaps have such opportunities. Maine should be congratulated for its wisdom and foresight in caring for "all the children of all the people."

Appointment of Dr. Luther E. Woodward

On February 15, 1943, Dr. Luther E. Woodward joined the staff of The National Committee for Mental Hygiene under a one-year grant from the Rockefeller Foundation. Dr. Woodward will give his entire time to assisting the Selective Service throughout the country by organizing social workers and other resources to help in better screening of registrants.

It has been found that social histories are a valuable aid in classification. Dr. Woodward will assist groups ready to give service to plan their programs.

It is unlikely that any one plan, such as that followed in New York or Connecticut, can be used in all states. The programs suggested by Dr. Woodward will, therefore, be flexible so as to take advantage of whatever service is available. States interested in giving this assistance to the Selective Service should communicate with Dr. Woodward.

New Appointment for Dr. Esther de Weerdt

Dr. Esther de Weerdt, formerly Executive Secretary of the Wisconsin Society for Mental Hygiene, has been nominated by the Acting Governor of Wisconsin, Walter S. Goodland, as a member of the State Board of Public Welfare. Dr. de Weerdt has been active in welfare work in Wisconsin for a number of years, and since 1937 has been with the Society for Mental Hygiene. She is also a member of the Board of the Wisconsin Welfare Council and is associated with many Beloit organizations engaged in welfare work. She received a Ph.D. in psychology at Yale and is a member of the American Psychological Association.

Death of Dr. Edwin B. Twitmyer

On March 3, 1943, Dr. Edwin B. Twitmyer, Professor of Psychology, Director of the Psychological Laboratory and Chief of the Corrective Speech Institute at the University of Pennsylvania, died at the Delaware County (Pennsylvania) Hospital after a brief illness.

Dr. Twitmyer, who was born on September 14, 1873, was graduated from Lafayette College in 1896. The following year he obtained his Master of Arts degree and in 1902 his degree of Doctor of Philosophy. In 1897, he entered his forty-six-year service in the Department of Psychology at the University of Pennsylvania. He was successively instructor, assistant professor, and professor in that department. In 1932, he was made Chief of the Corrective Speech Clinic, and in 1937, he became Director of the Psychological Laboratory.

Dr. Twitmyer, who was one of the outstanding psychologists in this country, was especially noted as an authority in the diagnosis and correction of speech defects, mental deficiency, and personality problems.

He leaves a widow, a daughter—Mrs. Frank J. Davies, of Lansdowne—and a son—Dr. Edward M. Twitmyer, who is Director of Personnel at Girard College, Philadelphia.

State Society News

Maryland

The executive secretary of the Mental Hygiene Society of Maryland has submitted the following report on the work of the past year:

Nearly 1,000 patients were given clinic service. Of the 590 new patients—286 adults and 304 children—365 were seen in the first six-months period, and 225 in the last. There were several reasons for the decrease:

1. More people are working and are economically independent. This has had an effect on the number and kinds of clients seeking service in all social and medical agencies.
2. We have examined fewer men for the Selective Service.
3. Clinical personnel has been reduced.
4. County clinic services have been curtailed.
5. Changes in the staff of the University Hospital have had some effect on the reference of cases to this department from the hospital.

It is with genuine regret that we announce the temporary suspension of this work. The step is forced upon us by reductions in staff and in transportation facilities, although the communities served are anxious to have the work continue.

Educational activities have included weekly lectures and clinics for third-year medical students during eleven months of the year, thirty-eight hours of lecturing to nurses in training at the Union Memorial Hospital, and thirty-three hours to the nurses at the University Hospital; five lectures to the nurses of the Western Health District; lectures to the Lenthicum Woman's Club; 102 addresses and lectures to county health groups and Parent-Teachers Associations.

The society has taken an active part in war work. Some of our activities are:

1. Assistance to the Maritime Commission in organizing the psychiatric work at the Bay Ridge Home for seamen who were suffering from having been torpedoed. After a study of the situation was made, a psychiatrist was recommended for the job and appointed, and is now on duty.
2. Service on the Medical Advisory Board of the Selective Service System.
3. The departure of the clinical director for overseas duty with the University Base Hospital Unit.
4. The varied work of the staff members in emergency medical service, air-raid-warden service, in the armed forces, and so on.
5. The appointment of the chief social worker by the Governor of Maryland to the Fair Rent Commission of the State Council of

Defense. She is also a member of the Woman Power Committee of the War Man-Power Commission and of several committees of the family and child-care division of the Council of Social Agencies.

The changes in the staff have been marked. Early in 1942, there were three full-time, one half-time, and five part-time psychiatrists on duty. At the close of the year there were on duty one full-time, one half-time, and one part-time psychiatrists.

In the social-work department there are only two full-time, one part-time, and one student workers.

Michigan

The Michigan Society for Mental Hygiene, through its secretary, Harold G. Webster, has issued its sixth annual report, covering the period from October 1, 1941, through September 30, 1942.

The principal activities may be listed as follows:

1. A legislative appropriation was gained for the State Hospital Commission for the establishment of three child-guidance clinics. Each clinic is staffed by a full-time psychiatrist trained in children's work, a psychologist, and a psychiatric social worker.

Each clinic will be the hub of a mental-health program for children and will serve schools, courts, health workers, private physicians, social workers, and parents.

2. The society and its local committees worked to secure a broad support for increased legislative appropriations to state hospitals, so that minimum salaries for attendants could be raised from $40 per month to $100 or more. This was essential if the program for care and treatment within hospitals was to be improved.

3. The society also worked to secure a legislative appropriation so that the Hospital Commission could employ a Director of Mental Health as required by the statute. Frank F. Tallman, M.D., of New York, a specialist trained in the field of mental illness and child psychiatry, was employed for the position. He began his work in Michigan, March 15, 1942. The Hospital Commission has resolved that Dr. Tallman will develop the following program:

> a. Organization, supervision, and coördination of the state child-guidance system;
>
> b. Establishment, supervision, and coördination of a family-placement-care program for certain types of patients now in state hospitals;
>
> c. Coördination and expansion of state-hospital out-patient clinics in collaboration with medical superintendents, with special attention to preventive and after-care aspects;
>
> d. Development of an integrated state-wide educational mental-health program.

4. A $100,000 appropriation was secured so that the Hospital Commission could begin a family-placement-care program in July,

1942, for patients in mental hospitals. It is estimated that from four to five hundred patients can eventually be removed from hospitals and placed in the family-boarding-care program.

5. The general program of education and interpretation has been carried on in much the same manner as last year—that is, by means of individual interviews, discussions, conferences, and lectures. More than 6,000 people attended 50 conference sessions. Approximately 9,000 copies of the *Mental Hygiene Bulletin* have been distributed to members, judges, legislators, libraries within the state, and other mental-hygiene societies in the country.

Certain immediate mental-health problems confront the citizens and officials of the state. Among the most pressing are:

1. The securing of public and legislative support for three additional child-guidance clinics under the supervision of the State Hospital Commission.

2. The providing of facilities for the care and treatment of children who are allegedly mentally ill or very much emotionally disturbed. As there is no provision made in the state for such children, it would be wise for the state to provide a special psychiatric hospital unit for children where they may receive diagnostic and treatment services by a staff especially trained in child psychiatry.

3. The caring for the large group of men rejected in this state by psychiatric examination at the army induction centers. It is hoped that the Michigan Mental Hygiene Society, the Michigan Society of Neurology and Psychiatry, and other community agencies can coöperate with induction centers in providing a program of consultation and guidance for those men who are screened out by the psychiatrist at the induction center.

4. The caring for the service men who have been discharged from the armed forces and returned to Michigan. These men are not eligible for treatment under the Veterans' Administration, which has spent on an average of $30,000 for each neuropsychiatric patient since the last war. This state cannot permit the mental illnesses of these men to go unattended until the progress of their illness requires institutional care.

Rhode Island

Dr. Temple Burling, Medical Director of the Providence Child Guidance Clinic, reports that the child-guidance clinic is now becoming an integral part of the life of Providence in other ways than simply treating sick children. Miss Roberta Andrews, the chief social worker, is chairman of a committee on the day care of children of working mothers, now the official subcommittee for the Committee on Welfare of the City Defense Council. Dr. Burling is Chairman of the Council of Social Agencies.

Mrs. William Lundy, one of the social workers of the clinic, has been given an indefinite leave of absence to be with her husband, Lieutenant Lundy. Mrs. Jean Mitchell is a part-time substitute for her.

In addition to the Providence Clinic, the organization now maintains community clinics in Cranston and Pawtucket. Early in 1943, a clinic will be opened in Warwick.

Texas

The Texas Society for Mental Hygiene held its work conference on March 5, 1943, at the Baker Hotel in Dallas, Texas. The theme was "Mental Hygiene at Work," and the emphasis was on those problems presented by war tensions. The executive board of the society met to discuss ways of taking the 1944 conference to the various regions over the state instead of having one central meeting. Each county unit sent a representative to this planning committee meeting.

After a business meeting, the pediatricians of Dallas gave a luncheon, followed by group meetings. The physicians of Dallas heard Lieutenant Colonel Franklin Ebaugh at the dinner meeting, and the night session was a summary of the afternoon's findings, presented by Mrs. Harry Overstreet, followed by an address by Dr. Chauncey D. Leake, of the University of Texas Medical School. These speakers were made available through the Hogg Foundation. Dr. Robert L. Sutherland, Director of the Hogg Foundation and acting president of the society, presided. Mrs. Eloise Sherman, of the Dallas Council of Social Agencies, was chairman of the local arrangements and was responsible for much of the planning.

The county societies for mental hygiene in Texas have been active in sponsoring a number of projects during the year. After the survey of mental hospitals made by Dr. S. W. Hamilton, of the United States Public Health Service, at the request of Governor Coke Stevenson, the county societies arranged discussion meetings in six of the principal cities of Texas. The Lomar County Society coöperated in presenting Mr. Russell Dicks in a three-day seminar before the chaplains of Camp Maxie at Paris, Texas. The Tarrant County Society was one of the co-sponsors of a three-day institute for social workers and teachers led by Dr. Herbert Chamberlain, consulting psychiatrist from the California Department of Social Welfare. The Hunt County Society has presented Dr. Chamberlain and Dr. Hamilton at local conferences.

Lieutenant Colonel Ebaugh, neuropsychiatric consultant for the Eighth Service Command, is asking the state society and the county societies to coöperate in making available to the induction centers social and health data concerning certain of the inductees. The state

society and the Hogg Foundation will coöperate in conducting a brief research project dealing with problems concerning soldiers who have received certificates of disability discharge for neuropsychiatric reasons.

The Travis County Society has started a youth information committee intended, not to take the place of clinic facilities, but to utilize whatever expert counsel a community may possess during war time. Emphasis is placed on providing information to youth particularly concerning military and civilian occupations, rather than upon dealing with personal adjustment problems on a case-work basis. The Travis County Society has also started a project for the distribution of mental-hygiene literature to group leaders in both rural and urban communities.

Washington

The Washington Society for Mental Hygiene has been handicapped this past year by the resignation of its executive secretary, Mrs. Helen Gibson Hogue, on July 1, 1942, and the loss of the following board members to the armed forces: Dr. Carroll C. Carlson, of Tacoma, and Drs. Douglass W. Orr, William Y. Baker, Edward D. Hoedemaker, and Frederick Lemere, all of Seattle. Dr. Herman Dickel has moved to Portland, Oregon.

As there was no executive secretary until November, 1942, the executive committee, under Dr. Ernest F. Witte, carried on the work.

In August, 1942, Dr. Witte reported that in the past year the society has concentrated on:

1. Education in mental-hygiene principles, particularly of parent and teacher groups. The value of this program is best demonstrated by the fact that the Seattle school board has employed a full-time person to carry on this service for the schools of Seattle.

2. A reference service. Numerous persons with mental and emotional problems, either their own or among members of their families, seek out the society for advice. The society secures enough information about the situation to be able to make an intelligent reference to the best sources of help.

3. A library service where books may be borrowed and pamphlets purchased.

4. An annual institute on mental hygiene, which has an attendance of from 200 to 650 persons.

The society has undertaken many other activities, including participation in many joint undertakings with other agencies, but major emphasis has been placed upon the four activities mentioned above.

Plans for the future are best set forth by quoting directly from the report of the committee:

> "The committee has given careful consideration as to what the future program should be. There are many services needed by this community, especially at this time, which the society might be expected to provide, but since our resources are limited, we are attempting to reorient our program in accordance with what seems to be most needed. In so doing, we recognize that the Mental Hygiene Society is basically committed to an educational program. Specifically the society plans:
>
> "1. To continue educational programs through institutes, speeches and printed matter, working with as many groups as possible. Some part of this interpretation will need to do with the anxieties caused by the war.
>
> "2. To continue reference service.
>
> "3. To continue library and information service.
>
> "4. To inaugurate consultation service to other agencies. The need to work with those agencies dealing with juvenile delinquency and its prevention are well understood.
>
> "5. To work with the Red Cross in the training of home-nursing aides, nurses' aides, and Gray Ladies, and with the War Commission in the training of junior hostesses.
>
> "6. To work with the State Defense Council through the State Department of Social Security in training volunteers and especially in developing staff to assist in day-care programs and day nurseries for children of working mothers.
>
> "7. To organize a program for helping rejected selectees and returning service men to reëstablish themselves in the community. This problem requires earnest attention, especially as regard to those rejected for mental reasons.
>
> "8. To assist in developing methods of selecting for the armed forces those who are mentally fit."

On October 20, 1942, Dr. Witte reported that Miss Marjorie C. Rice, a graduate of Mills College and of the School of Social Service Administration, Chicago, had been appointed executive secretary of the society and would begin her services in November.

After her professional training, Miss Rice returned to California and took a case-work position in Alameda County. Later she became mental-hygiene supervisor with the San Joaquin County Schools in Lodi, California.

In January, 1943, Miss Rice reported that Dr. Ernest F. Witte, president of the society, had been commissioned a major in the army and ordered to the University of Virginia for training in military government. Mr. Wayne Dick, of the Seattle Public Schools, first vice-president of the society, will act as president during Dr. Witte's absence.

New Publications

With a February, 1943, issue the *Family Community Digest* was launched. It is designed to promote democratic home and community life.

It will present through original contributions, as well as through abstracts and condensations of books, the important findings on such subjects as civilian health and safety, child and family life in war time, consumer education, interfamily coöoperation, creative school practices, and the community rôle of women.

The *Digest* is jointly sponsored by the National Council of Parent Education, the Vassar College Summer Institute for Family and Child Care Services in War Time, the Institute on Personality Development, the Merrill-Palmer School, and the Progressive Education Association.

This magazine is published bi-monthly, February through December, by the National Council of Parent Education and coöperating agencies, at Vassar College, Poughkeepsie, New York. The subscription price is one dollar for six issues; single copies, thirty-five cents.

Dr. H. N. MacCracken, President of Vassar College, states that "the *Family Community Digest* is in no sense a Vassar enterprise. It is a national enterprise designed to fill a genuine need in correlating the facts and opinions over a vast area of human relations. In this critical period of world history, we are more than ever concerned for the integrity of our foundations. In its draft regulations, its social administration, its public health, and many other agencies and functions, our government has shown a determination that the family shall be preserved through the long trial of war. The *Family Community Digest* covers the news in a field absolutely essential whether in war or in peace."

The Oregon Mental Hygiene Society has issued a leaflet entitled *New Ways of Living in Wartime.* It is designed primarily for discussion groups for the people of Portland, Oregon, but other communities could adopt the topics to suit their own needs.

These discussions fall into five groups:

I. New Faces, New Places. 1. When a family moves into a new community what values does it leave behind? 2. How are new values formed? 3. How are new friends made? 4. How does one judge those who are strange to him? 5. Can friendships be undertaken too quickly? 6. What room is there for newcomers in the Church, the school, in community recreation and education? 7. Who is the better able to meet the world, the man or woman who can change living habits or the one who cannot?

II. Woman's Work Is Never Done. 1. How may mothers think clearly about the reasons for working outside their homes? 2. How may employed mothers arrange for the care of their children? 3. For the care of the home? 4. Should household tasks be shared by the father? 5. By the children? 6. What values are there in sharing? What hazards? 8. What is the community doing to help working mothers with their problem?

III. Who Is the Head of the Household? 1. What determines the "balance of power" in the home? 2. Why have men in the past been considered to have more authority than women? 3. Are conditions changing now? 4. What part does the earning of money by women play? 5. Who should have the greater authority over the children? 6. What decisions should be made by each person for himself? 7. What kind of decisions involve the welfare of more than one person?

IV. The Child in a World at War. 1. When wartime brings new ways of living, what is the cost or benefit to our children? 2. How may we keep close to our children as their companions, even though we spend less of our time with them? 3. How are our children affected by our own courage, our resourcefulness, our health, our fatigue, our forms of recreation?

V. "If I Had as Much Money as I Could Spend?" 1. They say of money, "You can't take it with you." How may we turn money into things that we can take with us? 2. What do we want of life? 3. How can money buy those things? 4. In ten years from now what will have happened to our income of 1943? 5. What values can money bring in new experiences, in education, in new skills?

Any one interested in developing discussion groups in his community may write to Mr. Dan L. Prosser, Executive Secretary, Oregon Mental Hygiene Society, Platt Building, 519 West Park, Portland, Oregon.

The United States Public Health Service has issued an interesting bulletin entitled *National Negro Health News.*

The bulletin gives reports of the excellent work that is being done among the Negroes in both rural and urban communities. Intensive warfare is being waged against tuberculosis and venereal disease.

Another feature is entitled *Within Book Covers.* This section gives a good summary of the new books that would aid education and social workers. One particularly timely review is on *Victory versus V. D.* (Venereal Diseases) published by the United States Health Service. In it Dr. Parran, Surgeon General, states that "the public-health forces are fighting venereal disease with trained personnel. But there is more to this fight—these diseases are spread by the people. The chief source of infection is the ugliest and oldest racket in the world

—prostitution. America cannot afford to lose soldiers and workers because of preventable syphilis and gonorrhea.

"We must act—and act together—to-day—not alone for Victory in the military service, but Victory for a free and healthy mankind."

Blood Donors Needed

An urgent appeal has been sent out asking for blood donors. Plasma is a necessary element in saving lives. Any one who is able and willing to give any amount of blood up to a pint is asked to get in touch with the American Red Cross, 2 East 37th St., New York, N. Y., or any local chapter. Please do not delay, for your blood may save some one's life.

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Complied by

EVA R. HAWKINS

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